MEDICARE MISMANAGEMENT: OVERSIGHT OF THE FEDERAL GOVERNMENT EFFORT TO RECAPTURE MISSPENT FUNDS

HEARING

BEFORE THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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MEDICARE MISMANAGEMENT: OVERSIGHT OF THE FEDERAL GOVERNMENT EFFORT TO RECAPTURE MISSPENT FUNDS

Tuesday, May 20, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE, AND ENTITLEMENTS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:34 a.m., in Room 2154, Rayburn House Office Building, Hon. James Lankford [chairman of the subcommittee] presiding.

Present: Representatives Lankford, Gosar, Chaffetz, Jordan, Woodall, Speier, Norton, Lujan Grisham, Horsford, and Duckworth.

Also Present: Representatives Issa and Meadows.

Staff Present: Brian Blase, Professional Staff Member; Molly Boyl, Deputy General Counsel and Parliamentarian; Caitlin Carroll, Press Secretary; Sharon Casey, Senior Assistant Clerk; Katelyn E. Christ, Professional Staff Member; John Cuaderes, Deputy Staff Director; Adam P. Fromm, Director of Member Services and Committee Operations; Linda Good, Chief Clerk; Meinan Goto, Professional Staff Member; Mark D. Marin, Deputy Staff Director of Oversight; Jessica Seale, Digital Director; Tamara Alexander, Minority Counsel; Jaron Bourke, Minority Director of Administration; Aryele Bradford, Press Secretary; Devon Hill, Minority Research Assistant; Jennifer Hoffman, Minority Communications Director; Una Lee, Minority Counsel; and Donald Sherman, Minority Counsel.

Mr. LANKFORD. The committee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time. We will take this a little bit out of order today. As we walk through this, we have some of the Democrat members who are on their way here, but we will have the opening statements, and a lot of them will be able to catch up.

This is a subcommittee hearing on the Energy Policy, Health Care and Entitlements called Medicare Mismanagement: Oversight of the Federal Government Effort to Recapture Misspent Funds.

I'd like to begin this hearing by saying the Oversight Committee mission statement. We exist to secure two fundamental principles. First, Americans have the right to know the money Washington takes from them is well spent; and second, Americans deserve an efficient, effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect

these rights. Our solemn responsibility is to hold government accountable to taxpayers, because taxpayers have a right to know what they get from their government.

We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

Medicare currently pays one-fifth of all health care services provided nationwide, making it the largest single purchaser of health care in the country. Unfortunately, every year the Medicare program wastes an enormous amount of money in overpayments, fraud and unnecessary tests and procedures.

According to the Government Accountability Office, in 2013, $50 billion was lost to improper payments, an increase of $5 billion from 2012. Medicare fee for service accounted for $36 billion of this total. GAO has related Medicare as a high risk since 1990, in part, due to the program's susceptibility to this waste, which make up a staggering 47 percent of total improper payments identified by the Federal Government last year.

Growth in Medicare misspending and fraud represents a significant threat, not only to the 50 million beneficiaries who depend on its services, but also the program's finances. At present, the Medicare trust fund has been in deficit since 2008, and the Medicare actuaries predict the fund will be fully depleted by 2026.

The Centers for Medicare and Medicaid Services has the responsibility to maintain the program integrity of Medicare. To combat fraud, CMS works in partnership with several outside organizations, like the Health Care Fraud Prevention and Enforcement Action Team, which operates Medicare fraud strike forces to combat perpetrators who often steal identities and falsify billing documents.

The agency recently implemented a risk-based screening to identify fraudulent Medicare providers and suppliers. In April of 2014, CMS also announced that fingerprint-based background checks would be conducted on high risk providers.

Temporary enrollment moratoriums have also been placed on some new Medicare providers and suppliers in areas that are high risk for fraud. CMS has even begun administering risk-based private sector technologies, like predictive analytics to identify possible fraudulent claims for review.

CMS also relies on four types of contractors to combat improper payments. These contractors, such as the recovery audit contractors, or RACs, review claims to identify overpayments and then recover the misspent funds. GAO and others have found that these contractors' efforts sometimes overlap and the requirements to responding to audits are not uniform. This puts a greater burden on providers. The GAO has recommended that improving consistency among contractors would improve efficiency of post-payment reviews of Medicare claims.

Once improper payments are identified, CMS may take steps to reclaim identified overpayments. Providers and beneficiaries are given an opportunity to appeal these determinations through a lengthy appeals process. This third level of appeal is administered

by 66 administrative law judges at HHS's Office of Medicare Hearings and Appeals.

There is currently a massive backlog of over 460,000 pending appeals for ALJ hearings. Due to this backlog, HHS has stated it currently takes up to 28 months for a hearing before an ALJ, during which, providers have their money held by the government. Not many businesses can survive having their money held for 28 months while they wait to decide if they're actually going to get reimbursed.

The committee invited chief ALJ Nancy Griswold to testify today on these issues, but she was unable to appear, but we will follow through on that.

Today we have three witnesses: Kathleen King, Director of Health Care at the Government Accountability Office; Brian P. Ritchie, Acting Director Inspector General for Evaluation of Inspection at the HHS Office of the Inspector General; and Dr. Shantanu Agrawal, Deputy Administrator and Director for the Center of Program Integrity at CMS, to discuss how CMS can improve Medicare oversight and program integrity. I look forward to their testimony.

The American people deserve a government that protects their tax dollars and uses them wisely. We must do more to strengthen the integrity of government programs overall, but particularly Medicare, given its enormous size and scope.

Clearly more needs to be done to improve the Federal Government's efforts to recover $50 billion in overpayments and other improper payments. I hope today's hearing will provide the subcommittee with some clarity about these areas, but the process cannot drive up the cost of health care for seniors and reduce their options for care. I look forward to the conversation we will have today.

With that, I recognize Ms. Lujan Grisham for an opening statement.

Ms. LUJAN GRISHAM. Good morning. Thank you, Chairman Lankford, for holding the hearing. I agree with the chairman that reducing waste and fraud and abuse in the Medicare program is critically important, not only to protect taxpayer funds, but as you just heard, it's also incredibly important to protect the health of our Nation's seniors and disabled adult population. And we have got a hundred—we have got more than 10,000 seniors aging into the Medicare program each day this year. It is now more important than ever that we ensure the integrity of Medicare funds and keep the Medicare promise alive for generations of future Americans.

I'm grateful to have Mr. Ritchie here on behalf of the Department's Office of Inspector General to speak about the OIG's efforts to do exactly that. The OIG, in conjunction with the Department of Justice, prosecutes some of the worst instances of health care fraud, providers billing for non-existent beneficiaries or services that were never provided, and providers who order unnecessary or, in fact, harmful procedures.

The health care Fraud and Abuse Program, a joint program under the direction of the attorney general and the Secretary of the Health and Human Services Department is a model for inter-agency cooperation and coordination. In fiscal year 2013, the HCFAC program recovered a record $4.3 billion in health care fraud judg-

ments and settlements. This is remarkable. I look forward to hearing from the assistant inspector general about how this was achieved and what can be done to strengthen the program going forward, but I also think it is important to underscore what we've heard, is that these bad actors represent a small fraction of all providers.

A vast majority of providers are not fraudsters and are deeply dedicated to the care of their patients. And given the size and complexity, the theme of Medicare programs, overpayments are going to occur, and CMS must be vigilant in detecting and recouping them, but well meaning providers are entitled to have their claims administered fairly, efficiently and without undue delay so that they can focus on the core mission of providing care.

And I have some serious concerns that the current system of post-payment audits by RACs is resulting in a significant burden on some providers, particularly smaller entities. Smaller providers, such as durable medical equipment, or DME suppliers, have more difficulty complying with RAC requests for medical documentation and may not have the resources to, in fact, even appeal overpayment determinations.

The considerable backlog in the Office of Medicare Hearings and Appeals only makes these matters worse, as these providers and suppliers do not have the luxury of waiting months for their appeals to be adjudicated.

I also have concerns about how RAC audits may affect beneficiaries. As a representative of the New Mexico's First District, the issue of access to care is always paramount in my mind. If a provider or a supplier is forced to cut back services or close its doors as a result of a RAC audit, I think this is a lose-lose situation for everyone, particularly as we're working to build access to care, particularly preventative care for these populations.

CMS recently announced that it will implement several changes to the RAC program, which will be effective with the next RAC program contract awards. Now, I look forward to hearing from Dr. Agrawal about CMS's efforts to improve the oversight of the RACs in particular.

I hope that you will also address some of the issues we've both raised, the chairman and I, regarding the burden on Medicare providers, and with a particular focus on some of those smaller providers or providers in rural and frontier States like mine, and the impact that that has directly on the beneficiaries who are working to access those services.

I also look forward to hearing from all of the witnesses about what CMS is doing to move away from the pay-and-chase model to a more proactive model that identifies improper payments upfront. Such a model would spare both providers and taxpayers from expending resources that could be much better spent on providing care, which, in the long-run, shores up Medicare for future generations.

With that, Mr. Chairman, I yield back.

Mr. LANKFORD. We'll go to Mr. Meadows for an opening statement.

Mr. MEADOWS. Thank you, Mr. Chairman, for holding this hearing and thank you for continuing to highlight that we need to make sure that the American taxpayers' money is well protected.

This particular hearing is of importance to me, primarily because I have some constituents that have been caught up in this ALJ backlog, and as the ranking member just testified, it can be extremely difficult on small businesses. The request for a particular company in my district threatens to put them out of business, and yet all they want is a fair hearing. I shared this with the chairman and shared some of my concerns that where we are. And in his own opening statement, he talked about the fact that we have a 28-month backlog. Well, actually, it's worse than that. If you look at the real numbers, that today, if we hired, according to the budget request for CMS, if we hired all the adjudicators, it would take close to 10 years to work through this backlog, some million—a million appeals. And if you look at the rate—and actually the adjudicators have been improving their efficiency, they've been getting better year after year, and yet what we do is we have a policy of where we're saying you're guilty until proven innocent.

And we're all against waste, fraud and abuse, but what we must make sure of is that we do it under the rule of law and that we have laws that guide—the guidelines that are there. There is law right now that says that if we ask—if a constituent asks for a hearing, that the law says that they should have some kind of adjudication and a decision within 90 days, and yet even according to the website there for CMS, we're not even opening the mail for weeks and months and months and months.

So it's not even being put in terms of on the docket where it can be assigned to a judge for many, many months. We've got to do better than this and make sure that in this, we don't take those that are innocent and put them out of business.

Now, I say that because if our overturn rate was not that great, we wouldn't have a problem, but according to documents, many of these appeals are being overturned by the adjudicators. Over 50 percent of them are being overturned. So you have over 50 percent of the people who are innocent, who are having to wait years for a decision, and in that, we must do better and we must find a better way to address this.

So I look forward to hearing your testimony on all these things. And I thank you, Mr. Chairman.

Mr. LANKFORD. Thank the gentleman for all of his work and his research that has gone into this hearing this day, and he's been a leader in this.

I'd be glad to be able to receive the testimony now of our three witnesses. Pursuant to committee rules, all witnesses are sworn in before they testify, so if you'd please rise and raise your right hand.

Do you solemnly swear that the testimony that you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. LANKFORD. Thank you. Let the record reflect all three witnesses answered in the affirmative. You may be seated.

Ms. Kathleen King is the director for Health Care at the United States Government Accountability Office. Thank you for being here; Dr. Agrawal is the Deputy Administrator and director for the

Center for Program Integrity at CMS, and Mr. Brian Ritchie is the Acting Deputy Inspector General for Evaluation and Inspections at the Office of Inspector General at HHS.

Thank you all for being here and thanks for your testimony today. We've all received your written testimony. That will be a part of the permanent record. We would now be glad to be able to receive your oral testimony as well. In order to allow time for discussion, I ask you to limit your oral testimony to 5 minutes. You'll see the clock there in front of you.

Ms. King, you are first.

WITNESS STATEMENTS

STATEMENT OF KATHLEEN KING

Ms. KING. Mr. Chairman and members of the subcommittee, thank you for inviting me to talk about our work regarding Medicare improper payments.

CMS has made progress in implementing our recommendations to reduce improper payments, but there are additional actions they should take. I want to focus my remarks today on three areas: provider enrollment, pre-payment claims review, and post-payment claims review.

With respect to provider enrollment, CMS has implemented provisions of the Patient Protection and Affordable Care Act to strengthen the enrollment process so that potentially fraudulent providers are prevented from enrolling in Medicare, and higher risk providers undergo more scrutiny before being permitted to enroll. CMS has recently imposed moratoria on the enrollment of certain types of providers in fraud hotspots, and has contracted for fingerprint-based background checks for high risk providers; however, CMS has not completed certain actions authorized in PPACA, which would also be helpful in fighting fraud. It has not yet published regulations to require additional disclosures of information regarding actions previously taken against providers, such as payment suspensions, and it has not published regulations establishing the core element of compliance programs or requirements for surety bonds for certain types of at-risk providers.

With respect to review of claims for payment, Medicare uses prepayment review to deny payment for claims that should not be paid and post-payment review to recover improperly paid claims. Prepayment reviews are typically automated edits and claims processing systems that can prevent payment of improper claims. For example, some pre-payment edits check to see whether the claim is filled out properly and that the provider is enrolled in Medicare. Other pre-payment edits check to see whether the service is covered by Medicare.

We found some weaknesses in the use of pre-payment edits and made a number of recommendations to CMS to promote implementation of effective edits regarding national policies and to encourage more widespread use of local policies by contractors. CMS agreed with our recommendations and has taken steps to implement most of them.

Post-payment claims reviews may be automated like pre-payment reviews or complex, which means that trained staff review

medical documentation to determine whether the claim was proper. CMS uses four types of contractors to perform most post-payment reviews. We recently completed work that examines CMS's requirements for these contractors and found differences that can impede efficiency and effectiveness by increasing administrative burden on providers. For example, the minimum number of days contractors must give providers to respond to a request for documentation of a service ranges from 30 to 75 days. We recommended that CMS make the requirements for these contractors more consistent when it would not impede the efficiency of efforts to recover improper payments. CMS agreed with our recommendation and is taking steps to implement them.

We also have further work underway on the post-payment review contractors to examine whether CMS has strategies to coordinate their work and whether these contractors comply with CMS's requirements regarding communications with providers.

Although the percentage of claims subject to post-payment review is very small, less than 1 percent of all claims, the number of post-payment reviews has increased substantially in recent years. From 2011 to 2012, the number of these reviews increased from 1.5 million to 2.3 million. This is one factor contributing to a backlog and delays in resolving appeals by administrative law judges.

We have been asked to examine the appeals process, including reasons for the increase, its effects on beneficiaries, providers and contractors, and options to streamline the process.

In conclusion, because Medicare is such a large and complex program, it is vulnerable to improper payments and fraud and abuse. Given the level of improper payments in Medicare, we urge CMS to use all available authorities for preventing, identifying and recouping improper payments.

This concludes my prepared remarks. Thank you.

[Prepared statement of Ms. King follows:]

GAO Highlights

Highlights of GAO-14-619T, a testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

Due to its size, complexity, and susceptibility to mismanagement and improper payments, GAO has designated Medicare as a high-risk program. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion, and reported an estimated $50 billion in improper payments—payments that either were made in an incorrect amount or should not have been made at all. Most of these improper payments were made through the Medicare FFS program, which pays providers based on claims and uses contractors to pay the claims and ensure program integrity.

This statement focuses on the progress made and steps still to be taken by CMS to improve improper payment prevention and recoupment efforts in the Medicare FFS program. This statement is based on relevant GAO products and recommendations issued from 2007 through 2014 using a variety of methodologies. GAO also updated information by examining public documents and, in April 2014, GAO received updated information from CMS on its actions related to laws and regulations discussed in this statement.

View GAO-14-619T. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

May 20, 2014

MEDICARE

Further Action Could Improve Improper Payment Prevention and Recoupment Efforts

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has made progress improving improper payment prevention and recoupment efforts in the Medicare fee-for-service (FFS) program, but further actions are needed.

Provider enrollment. CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) that address past weaknesses identified by GAO and others. The agency has also put in place other measures intended to strengthen existing procedures, but could do more to improve provider enrollment screening and ultimately reduce improper payments. For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses, meet certain Medicare standards, and are at legitimate locations. CMS also recently contracted for fingerprint-based criminal history checks of providers and suppliers it has identified as high-risk. However, CMS has not implemented other screening actions authorized by PPACA that could further strengthen provider enrollment.

Prepayment controls. In response to GAO's prior recommendations, CMS has taken steps to improve the development of certain prepayment edits—prepayment controls used to deny Medicare claims that should not be paid; however, important actions that could further prevent improper payments have not yet been implemented. For example, CMS has implemented an automated edit to identify services billed in medically unlikely amounts, but has not implemented a GAO recommendation to examine certain edits to determine whether they should be revised to reflect more restrictive payment limits. GAO has found that wider use of prepayment edits could help prevent improper payments and generate savings for Medicare.

Postpayment claims reviews. Postpayment claims reviews help CMS identify and recoup improper payments. Medicare uses a variety of contractors to conduct such reviews, which generally involve reviewing a provider's documentation to ensure that the service was billed properly and was covered, reasonable, and necessary. GAO has found that differing requirements for the various contractors may reduce the efficiency and effectiveness of such reviews. To improve these reviews, GAO has previously recommended CMS examine ways to make the contractor requirements more consistent. CMS reported that it has begun to address these recommendations. Although the percentage of Medicare claims that undergo postpayment review remains very small, GAO has found that the overall number of postpayment claims reviews has been increasing in recent years. HHS has reported that the increase in claims reviews is one factor causing backlogs in the Medicare appeals process.

GAO has ongoing work focused on how CMS could continue its efforts to reduce improper Medicare payments. For instance, GAO is examining the extent to which CMS's provider enrollment system can help prevent and detect the continued enrollment of ineligible providers in Medicare. GAO also has work underway to examine whether CMS has strategies for coordinating postpayment review contractors' claims review activities.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to be here today to discuss our work examining further action Medicare could take to improve its improper payment prevention and recoupment efforts.[1] In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion, and reported some of the largest estimates of improper payments among federal programs—payments that either were made in an incorrect amount or should not have been made at all.[2] Due to its size, complexity, and susceptibility to mismanagement and improper payments, we have designated Medicare as a high-risk program since 1990.[3]

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has estimated that improper payments in the Medicare program were almost $50 billion in fiscal year 2013.[4] CMS separately calculates error rates and performance targets for the Medicare fee-for-service (FFS) program, Medicare Advantage, and the Medicare Prescription Drug Benefit.[5] Medicare FFS accounted for more than 70 percent of Medicare's estimated improper payments in 2013. The Medicare FFS estimated improper payments were about $36 billion or about 10.1 percent of total FFS payments. This is about $6.5 billion

[1]Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

[2]An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

[3]GAO, *High-Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013)

[4]A list of abbreviations used in this statement is provided in appendix I.

[5]Medicare consists of four parts. Parts A and B are known as Medicare FFS. Part A covers hospital and other inpatient stays and Part B covers hospital outpatient, physician, and other services. Part C, also known as Medicare Advantage, is the private plan alternative to Medicare FFS under which beneficiaries receive benefits through private health plans. Part D is the outpatient prescription drug benefit.

higher than in 2012 and did not meet the fiscal year 2013 target error rate of 8.3 percent that the agency set for itself to reduce improper payments.[6] Improper payments may be a result of fraud, waste, or abuse, but it is important to distinguish that the $50 billion in estimated improper payments reported by CMS in fiscal year 2013 is not an estimate of fraud in Medicare.[7] Reported improper payment estimates include many types of payments that should not have been made or were made in an incorrect amount such as overpayments, underpayments, and payments that were not adequately documented.

According to HHS, the primary cause of improper payments in Medicare FFS was administrative and documentation errors in large part due to insufficient documentation, meaning the medical records submitted by the provider or supplier were inadequate to support payment for the services billed.[8] HHS has reported that physicians and suppliers substantially contributed to insufficient documentation errors. HHS also cited the provision of services that were found not to be medically necessary and incorrect diagnosis coding as causes for FFS improper payments. Medical necessity errors occur, for example, when a claim is paid for a service that should have been provided in a less intensive setting. This error type has accounted for the majority of Part A inpatient hospital improper payments. For Medicare Advantage, HHS reported that the majority of the improper payment estimate resulted from insufficient documentation to support the diagnoses submitted by private health plans for payment. HHS cited administrative and documentation errors as the cause for all improper payments in the prescription drug benefit. Despite

[6]See Department of Health and Human Services, *Fiscal Year 2012 Agency Financial Report* (Washington D.C.: Nov 15, 2012).

[7]Fraud consists of intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

[8]Department of Health and Human Services, *Fiscal Year 2013 Agency Financial Report* (Washington D.C.: Dec 16, 2013). Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate improper payment estimates. The CERT program categorized five types of errors—no documentation, insufficient documentation, medical necessity, incorrect coding, and other errors (such as duplicate payments). In this statement, the term provider includes entities such as hospitals or physicians, and supplier means an entity that supplies Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) such as walkers and wheelchairs.

CMS efforts to address these causes, reducing Medicare improper payments continues to be a challenge.

Today, my testimony will focus on the progress made and steps still needed by CMS to reduce improper payments in the Medicare FFS program. I will focus on CMS's progress with respect to three key strategies we have identified in prior work that can help prevent improper payments and recoup overpayments:

- Strengthening provider enrollment standards and procedures to help reduce the risk of enrolling entities intent on defrauding the program;
- Improving prepayment controls, to ensure that claims are paid correctly the first time; and
- Improving postpayment claims review and recovery of improper payments to reduce the likelihood of improper payments and recoup overpayments.

My statement today is based primarily on previous GAO reports related to Medicare program integrity efforts issued between January 2007 and April 2014. A list of related GAO products is included at the end of this statement.[9] We supplemented prior work with additional information on Medicare improper payments reported by HHS in its fiscal year 2013 agency financial report and with other publicly available information from HHS's website on Medicare appeals, and we received updated information from CMS in April 2014 on its actions related to relevant laws, regulations, and recommendations that had not yet been implemented discussed in this statement. Our work for this statement and the products on which it was based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[9]The products listed at the end of this statement contain detailed information on the various methodologies used in our work.

CMS Has Improved Key Strategies for Preventing and Recouping Improper Payment, but More Can Be Done

CMS has made progress strengthening provider enrollment procedures and prepayment controls in the Medicare program to help ensure that payments are made correctly the first time, but the agency could further improve upon its efforts by implementing additional enrollment procedures and prepayment strategies. Likewise, additional improvements to CMS's postpayment claims review activities could improve their efficiency and effectiveness.

CMS Has Implemented Certain Enrollment Procedures to Better Screen Providers, but Has Not Completed Others

CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) and put in place other measures intended to strengthen existing procedures.[10] The changes to provider screening procedures are intended to address past weaknesses identified by GAO and the HHS's Office of Inspector General (OIG) that allowed entities intent on committing fraud to enroll in Medicare. Blocking the enrollment of such providers helps to prevent Medicare from making improper payments. Specifically, CMS added screenings of categories of provider enrollment applications by risk level and contracted with new national enrollment screening and site visit contractors.

- *Screening Provider Enrollment Applications by Risk Level*: CMS and the OIG issued a final rule in February 2011 to implement many of the new screening procedures required by PPACA.[11] CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers at each level. Providers in the high-risk level are subject to the most rigorous screening. Based in part on our work and that of the OIG, CMS designated newly enrolling home health agencies and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as high risk, and designated other providers as lower risk.

[10]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[11]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011). In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine whether a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

Providers at all risk levels are screened to verify that they meet specific requirements established by Medicare, such as having current licenses or accreditation and valid Social Security numbers. High- and moderate-risk providers are also subject to unannounced site visits.

Further, PPACA authorizes CMS to require fingerprint-based criminal background checks of providers and suppliers depending on the risks presented. In March 2014, CMS awarded a contract to a Federal Bureau of Investigation-approved contractor that will enable the agency to access criminal history information to help conduct those checks of high-risk providers and suppliers. CMS has indicated that the agency will continue to review the criteria for its screening levels and will publish changes if the agency decides to update the assignment of screening levels for categories of Medicare providers. Doing so could become important because the Department of Justice and HHS reported multiple convictions, judgments, settlements, or exclusions against types of providers not currently at the high-risk level, including community mental health centers and ambulance providers.[12]

- *National Enrollment Screening and Site Visit Contractors*: CMS contracted with two new contractors at the end of 2011 to assume centralized responsibility for two functions that had been the responsibility of multiple contractors. One of the new contractors is conducting automated screenings to check that existing and newly enrolling providers and suppliers have valid licensure, accreditation, and a National Provider Identifier, and are not on the OIG list of providers and suppliers excluded from participating in federal health care programs. The second contractor conducts site visits of providers to determine whether sites are legitimate and the providers meet certain Medicare standards. A CMS official reported that, since the implementation of the PPACA screening requirements, the agency

[12]Department of Health and Human Services and the Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (Washington, D.C.: February 2014).

had revoked over 17,000 suspect providers' privileges to bill the Medicare program.[13]

Although CMS has taken actions to strengthen the provider enrollment process, we and the OIG have found that CMS has not taken other actions authorized by PPACA and that could improve screening and ultimately reduce improper payments.[14] They include issuing a rule to require surety bonds for certain providers and suppliers as well as a rule on provider and supplier disclosure requirements.

- *Surety Bonds*: PPACA authorized CMS to require a surety bond for certain types of at-risk providers and suppliers.[15] Surety bonds may serve as a source for recoupment of erroneous payments. DMEPOS suppliers are currently required to post a surety bond at the time of enrollment.[16] CMS told us in April 2014 that the agency collected about $1.6 million in DMEPOS supplier overpayments between February 2012 and March 2013. However, also in April 2014, CMS reported that it had not scheduled for publication a proposed rule to impose a surety bond requirement as authorized by PPACA for other types of at-risk providers and suppliers—such as home health agencies and independent diagnostic testing facilities.
- *Providers and Suppliers Disclosure*: CMS has not yet scheduled the publication of a proposed rule for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has been subject to a payment suspension from a federal health care

[13]S. Agrawal, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, *Preventing Medicare Fraud: How Can We Best Protect Seniors and Taxpayers?*, testimony before the Senate Special Aging Committee, March 26, 2014.

[14]GAO, *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*, GAO-12-351 (Washington, D.C.: Apr. 10, 2012).

[15]A surety bond guarantees that if a provider or supplier does not fulfill its obligation to Medicare, CMS can recover its losses via the surety bond.

[16]42 U.S.C. § 1395m(a)(16)(B). A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, the surety bond is paid to Medicare. *Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies*, 74 Fed. Reg. 166 (Jan. 2, 2009).

program.[17] As we reported in April 2012, agency officials indicated that developing the additional disclosure requirements has been complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.[18]

We are currently examining the ability of CMS's provider enrollment system to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in Medicare. Specifically, we are assessing the process used to enroll and verify the eligibility of Medicare providers in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) and the extent to which CMS's controls are designed to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in PECOS.[19]

CMS Has Improved Prepayment Controls, but More Could Be Done to Prevent Improper Payments

CMS has enhanced its efforts to reduce improper payments by improving prepayment controls, particularly prepayment edits to deny claims that should not be paid. CMS has stated that one of its key goals is to pay claims properly the first time—that is, to ensure that payments go to legitimate providers in the right amount for reasonable and necessary services covered by the program for eligible beneficiaries. To do so, among other things, CMS uses prepayment controls such as prepayment edits—instructions that CMS's contractors, including Medicare Administrative Contractors (MAC), program into claims processing systems that compare claim information to Medicare requirements in

[17]At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose, in a form and manner and at such time as determined by the Secretary, any current or previous affiliation with another provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or State Children's Health Insurance Program; or has had its billing privileges denied or revoked. Pub. L. No. 111-148, § 6401(a), 124 Stat. 119, 750 (2010).

[18]GAO-12-351.

[19]PECOS is CMS's centralized database for Medicare enrollment information. To bill Medicare, providers and suppliers must first enroll in PECOS and as part of the enrollment process CMS contractors validate certain provider information.

order to approve or deny claims or to flag them for additional review.[20] For example, some prepayment edits are related to service coverage and payment, while others are implemented to verify that the claim is properly filled out, that providers are enrolled in Medicare, or that patients are eligible Medicare beneficiaries.[21] Most of the edits implemented by CMS and its contractors are automated and applied to all claims; if a claim does not meet the criteria of the edits, it is automatically denied. Other prepayment edits are manual; they flag a claim for individual review by trained staff to determine whether it should be paid.

We previously evaluated CMS's implementation of prepayment edits and found that while use of prepayment edits saved Medicare at least $1.76 billion in fiscal year 2010, the savings could have been greater had prepayment edits been used more widely.[22] For example, based on our analysis of a limited number of national policies and local coverage determinations in 2012,[23] we identified $14.7 million and $100 million in payments, respectively, that were inconsistent with policies and determinations and were therefore improper. Such inconsistencies could have been identified using automated edits.

As we recommended, CMS has taken steps to improve the development of certain prepayment edits that are implemented nationwide. For example, the agency has centralized the development and

[20]Some edits use provider enrollment information, while others use information on coverage or payment policies, to determine whether claims should be paid. MACs process and pay FFS claims. In addition to MACs, CMS has other types of contractors to help identify and recover improper payments, address fraud and abuse, or develop specific types of edits.

[21]For more information on the scope of prepayment coverage, payment and coding edits, see GAO, *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, GAO-13-102 (Washington, D.C.: Nov. 13, 2012).

[22]GAO-13-102.

[23]CMS typically develops national coverage determination policies for services that have the potential to affect a large number of beneficiaries and that have the greatest effect on the Medicare program. Development of national coverage determinations is a lengthy process, which requires review of clinical evidence and allows for public comment. In addition, each MAC has the authority to develop local coverage determinations (LCDs) that delineate the circumstances under which services are considered reasonable and necessary and are therefore covered in the geographic area where that MAC processes claims.

implementation of automated edits based on a type of national policy called national coverage determinations.[24] In addition, CMS has modified its processes for identifying provider billing of services that are medically unlikely, in order to prevent circumvention of automated edits designed to identify an unusually large quantity of services provided to the same patient.[25] However, as of April 2014, CMS had not fully implemented several of the recommendations we made in 2013 that we believe would promote greater use of prepayment edits and better ensure proper payment.[26] For example, the agency did not include, in its written guidance to agency staff on procedures for ensuring consideration of automated edits, time frames for making decisions on whether an edit would be developed nor did it include requirements for assessing the effects of corrective actions taken. In addition, although CMS has taken initial steps to improve the data it collects about local prepayment edits implemented by its contractors, it had not yet determined a final process for how it would obtain and disseminate information about these edits across contractors.[27] Nor does CMS require contractors to share information with each other about the underlying policies and savings related to their most effective edits, as the agency currently lacks a database to collect such information. Having information about the most effective local edits would enable contractors to determine the most appropriate approach for implementing Medicare payment policy effectively, which could help reduce improper payments.

To help prevent improper payments, CMS also implemented a specific type of national edit, called a Medical Unlikely Edit (MUE), which limits the amount of a service that is paid when billed by a provider for a beneficiary on the same day. The limits for certain services that have been fraudulently or abusively billed are unpublished to deter providers from billing up to the maximum allowable limit. In 2013, we reported that CMS may be missing opportunities to prevent improper payments because it

[24]GAO, *Medicare Fraud: Progress Made, but More Action Is Needed to Address Medicare Fraud, Waste and Abuse*, GAO-14-560T (Washington, D.C.: Apr. 30, 2014).

[25]CMS refers to these automated edits as Medically Unlikely Edits (MUE).

[26]See GAO-13-102 for our recommendations related to our evaluation of CMS's implementation of prepayment edits.

[27]MACs may create prepayment edits to implement their LCDs. CMS has responsibility for providing information and oversight to MACs with respect to their use of prepayment edits to promote effective stewardship of Medicare funds.

has not systematically evaluated MUE limits to determine whether national edits should be revised to reflect more restrictive local limits.[28] In addition, we found that CMS and its contractors did not have a system in place for examining claims to determine the extent to which providers may be exceeding unpublished MUE limits and whether payments for such services were proper. As a result, we recommended that CMS examine contractor edits to determine whether any national unpublished MUE limits should be revised, consider reviewing claims to identify providers that exceed the unpublished MUE limits, and determine whether the provider's billing was proper. HHS agreed with these recommendations, but as of April 2014, CMS had not implemented them.

Postpayment Claims Reviews Have Increased in Recent Years, but More Could Be Done to Increase Consistency across Contractors

Medicare uses four types of contractors to conduct postpayment claims reviews to identify and recoup overpayments.[29] The contractors all use the same Medicare coverage and payment guidelines.

- MACs, in addition to conducting prepayment claims reviews, conduct postpayment claims reviews to help ensure accurate payment and specifically to identify payment errors. This includes identifying ways to address future payment errors—for example, through automated controls that can be added on a prepayment basis and by educating providers with a history of a sustained or high level of billing errors to ensure that they comply with Medicare billing requirements.
- Zone Program Integrity Contractors (ZPIC), the CMS contractors responsible for detecting and investigating fraud, perform postpayment claims reviews as a part of their investigations.[30]

[28]GAO, *Medicare Program Integrity: Few Payments in 2011 Exceed Limits Under One Type of Prepayment Control, but Reassessing Limits Could Be Helpful*, GAO-13-430 (Washington, D.C.: May 9, 2013).

[29]In this statement, we discuss the four types of primary contractors that perform claims reviews. In addition to these four, in 2012 CMS established the Supplemental Medicare Review Contractor type to perform national claims reviews of Medicare Part A, Part B, and durable medical equipment providers and suppliers. This type of contractor conducts large-volume medical reviews nationwide for specific services, such as Inpatient Psychiatric Facility Interrupted Stays, Epidural Injections, and Place-of-Service coding. We are not discussing this type of contractor because it was too new to examine during our most recent work on Medicare postpayment contractors.

[30]Program safeguard contractors conducted activities to investigate fraud prior to the establishment of ZPICs, and are still doing so in one of seven geographic zones.

Therefore, ZPIC reviews generally focus on providers whose billing patterns are unusual or aberrant in relation to those of similar providers in order to identify potential fraud.

- The Comprehensive Error Rate Testing (CERT) contractor estimates the Medicare FFS improper payment rate by using the results of postpayment claims reviews conducted on a sample of claims processed by the MACs. CERT reviews may also help identify program vulnerabilities by measuring the payment accuracy of each MAC, and the Medicare FFS improper payment rate by type of claim and service.
- Recovery audit contractors (RAC) conduct postpayment claims reviews to identify improper payments. Use of RACs was designed to be in addition to MACs' existing claims review processes, since the number of postpayment reviews conducted by MACs and other contractors was small relative to the number of claims paid and the amount of improper payments. Whereas RACs are paid on a contingency fee basis based on the amount of improper payments they recoup, the other three contractors are paid under the terms of their contract using appropriated funds.[31] In February 2014, CMS announced a "pause" in the RAC program as the agency makes changes to the program and starts a new procurement process for the next round of recovery audit contracts. CMS said it anticipates awarding all five of these new Medicare FFS recovery audit contracts by the end of summer 2014.[32]

All four types of contractors conduct complex reviews of claims. Complex reviews involve manual examinations of each claim and any related documentation requested and received from the provider, including paper files, to determine whether the service was billed properly, and was covered, reasonable, and necessary. Licensed clinical professionals, such as licensed practical nurses, and certified coders typically perform

[31]Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years. Typically, contractors that perform recovery audits are paid a contingency fee based on a percentage of the overpayments collected. In Medicare, the RACs are paid a contingency fee based on both the percentage of overpayments collected and underpayments identified.

[32]PPACA required the expansion of Medicare RACs to Parts C and D. See Pub. L. No. 111-148, § 6411(b) 124 Stat. 119, 775 (2010) (codified at 42 U.S.C. § 1395ddd(h). CMS has implemented a RAC for Part D, and CMS said it plans to award a contract for a Part C RAC by the end of 2014.

the reviews. Contractors have physician medical directors on staff who provide guidance about making payment determinations on the basis of medical records and other documentation and who may discuss such determinations with providers.

In addition to conducting complex reviews, RACs also conduct automated and semiautomated postpayment claims reviews. Automated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes. Automated postpayment reviews analyze paid claims and identify those that can be determined to be improper without examining any additional documentation, such as when a durable medical equipment supplier bills for items that should have been included as part of a bundled payment for a skilled nursing facility stay.[33] Semiautomated reviews use computer programming logic to check for possible improper payments, but allow providers to send in information to rebut the claim denial before it is implemented. If providers send in information, RAC staff review it before making a final determination.

Our prior work has found that the overall number of postpayment claims reviews has been increasing in recent years, but remains a very small percentage of total Medicare claims submitted.[34] In 2012, the most recent year for which we have data, the four types of Medicare postpayment review contractors conducted about 2.3 million claims reviews, which is a 55 percent increase from 2011. RACs conducted about 2.1 million, or 90 percent, of these reviews in 2012. All four types of contractors listed except the CERT contractor increased the number of claims they reviewed in 2012, as shown in table 1.

[33]If the durable medical equipment claim is submitted prior to the bundled skilled nursing facility claim, the durable medical equipment claim may not appear to be improper when made.

[34]GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*. GAO-13-522 (Washington, D.C.: July 23, 2013).

Table 1: Volume of Contractors' Postpayment Claims Reviews, by Type of Contractor 2011-2012

Type of contractor	Type of review	2011	2012	Percent change
Medicare Administrative Contractors (MAC)[a]	Complex[b]	10,518	84,070	699%
Zone Program Integrity Contractors (ZPIC)[c]	Complex	92,655	107,621	16
Comprehensive Error Rate Testing (CERT) contractor	Complex	47,877	41,396	-14
Recovery Audit Contractors (RAC)[d]	Automated[e]	723,484	985,946	36
	Complex[f]	634,613	1,121,509	77
	Total	1,358,097	2,107,455	55
Total		**1,509,147**	**2,340,542**	**55%**

Source: GAO analysis of CMS data.

[a]Reviews completed by MACs do not include the reviews performed by the three legacy contractors that were continuing to provide claims administration services as of June 2013.

[b]Complex reviews are manual examinations of claims documentation including paper files, to determine whether the service was billed properly and was covered, reasonable, and necessary. They typically are performed by licensed clinical professionals or certified coders.

[c]Reviews completed by ZPICs include those performed by the program safeguard contractors (PSC) and reflect PSCs' reviews of potentially abusive physical therapy claims in one geographic area.

[d]RAC data are reported for fiscal years 2011 and 2012, rather than calendar year.

[e]Automated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes. Only the RACs conducted automated postpayment reviews.

[f]RAC complex reviews are based on the number of additional documentation requests received and also include semiautomated reviews.

While the number of postpayment reviews has increased significantly, the percentage of Medicare claims reviewed after payment remains small. The 2.3 million reviews performed by these four types of contractors accounted for less than 1 percent of the more than 1 billion FFS claims paid annually. About 1.4 million of the reviews were complex reviews which required the submission of documentation for review.

As a systematic matter, the increase in postpayment claims reviews is one factor causing backlogs and delays at the third level of the Medicare appeals process. Medicare providers and suppliers can appeal prepayment and postpayment claims determinations through the Medicare appeals process, which offers four levels of administrative review followed by judicial review. The first two levels of appeals for FFS claims are managed by two CMS contractors—the MAC that processed the original claim and a Qualified Independent Contractor, in that order.[35]

[35]There are five Qualified Independent Contractors that serve different areas of the country and focus on specific parts of the Medicare FFS program.

The third level of appeal is to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA), a separate staff division within HHS. A Part A or Part B appeal filed with OMHA should generally be decided within 90 days of the appeal being filed.[36] However, due to a backlog of cases, OMHA currently reports that the average time for appeals to be decided in fiscal year 2014 is 346 days.[37] The number of appeals filed at the ALJ level increased from 59,601 in fiscal year 2011 to 384,651 in fiscal year 2013, according to OMHA. OMHA's website currently says that new appeals will take about 28 months before they are put on an ALJ's hearing docket. OMHA has reported that part of the reason for the backlog in Medicare appeals is the increase in postpayment contractor activities. We have been asked to examine the Medicare appeals process, including the reasons for the appeals backlog and what HHS is doing to address it.

We have made recommendations to CMS in the past to improve the postpayment claims review process, and we continue to do work in this area. In October 2012, we reported on CMS's Fraud Prevention System (FPS), which uses predictive analytics to analyze Medicare FFS claims.[38] FPS is intended to detect aberrant billing practices as quickly as possible so they can be investigated to determine whether the payments are proper. At the time, we recommended that CMS integrate FPS with Medicare's payment-processing system to allow for the prevention of payments until suspect claims could be investigated by ZPICs. Although CMS reported in April 2014 that it had integrated the systems, the system still does not have the ability to suspend payment until suspect claims can be investigated. CMS has begun to implement prepayment edits in FPS that automatically deny claims based on attributes of the FPS edit which reviews the claim against historical claims across all lines of business.[39]

[36]OMHA also adjudicates other Medicare appeals, including those related to Part D prescription drug coverage. However, Part A and Part B appeals make up the vast majority of appeals made to OMHA.

[37]OMHA prioritizes beneficiary appeals and expedited appeals of Part D drug denials.

[38]GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

[39]CMS told us that it implemented the first FPS edit in January 2014 and that two additional FPS edits are planned for implementation in June 2014 and two more in September 2014.

In July 2013, we reported that the differences in CMS's postpayment claims review requirements for the four types of contractors may reduce the efficiency and effectiveness of claims reviews by complicating providers' compliance with the requirements.[40] For instance, while RACs have to obtain approval from CMS for the billing issues they choose to review on a widespread basis and notify providers and suppliers of those issues on their websites, the other contractors do not. In addition, the minimum number of days that CMS requires a contractor to give a provider to submit additional documentation for a complex review before the claim can be found improper for lack of documentation varies among the contractors from 30 days for ZPICs to 75 days for the CERT contractor. Staffing requirements and quality assurance requirements also vary among the four types of contractors. We recommended that CMS examine all postpayment review requirements for contractors to determine whether they could be made more consistent without negative effects on program integrity. We also recommended that CMS reduce differences in those requirements where it can be done without impeding the efficiency of its efforts to reduce improper payments. In commenting on that report, CMS agreed with our recommendations and stated that the agency was beginning to review its requirements for postpayment claims reviews. We are following up on this work with a study reviewing, among other things, whether CMS has strategies for coordinating postpayment review contractors' claims review activities.

In conclusion, given the amount of estimated improper payments in the Medicare program, the imperative for CMS to use all available authorities to prevent and recoup improper payments is clear. Although CMS has taken important steps to strengthen key strategies for identifying and preventing improper payments, the agency must continue to improve upon these efforts. Identifying the nature, extent, and underlying causes of improper payments and developing adequate corrective action processes to address vulnerabilities are essential prerequisites to reducing them. As CMS continues its implementation of PPACA, additional evaluation and oversight will help determine whether implementation of relevant provisions has been effective in reducing improper payments. We are continuing to conduct a body of work that assesses CMS's efforts to refine and improve its ability to prevent, identify, and recoup improper payments. Notably, we are currently

[40]GAO-13-522.

assessing the extent to which CMS's information system can help prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in Medicare. Additionally, we are examining CMS's oversight of some of the contractors that conduct postpayment reviews of claims including whether CMS has a strategy for coordinating these contractors' claims review activities. Separately, we have also been asked to examine the Medicare appeals process, including the reasons for the appeals backlog and how it is being addressed. Through this work, we hope to develop further recommendations for CMS to help the agency continue to refine its efforts to reduce improper Medicare payments.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Lori Achman, Assistant Director; Rebecca Abela; Jennel Lockley; and Jennifer Whitworth were key contributors to this statement.

Mr. LANKFORD. Thank you.
Dr. Agrawal.

STATEMENT OF SHANTANU AGRAWAL, M.D.

Dr. AGRAWAL. Thank you. Chairman Lankford, Ranking Member Lujan Grisham, and members of the subcommittee, thank you for the invitation to discuss the Centers for Medicare and Medicaid Service's program integrity efforts.

Program integrity is a top priority for the administration and an agency-wide effort at CMS. We share the subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity efforts.

I view program integrity through the lens of my experience as an emergency medicine physician, who fundamentally cares about the health of patients. Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive or fraudulent services, thus helping to extend the life of the trust fund, but the importance of program integrity efforts extend beyond dollars and health care costs alone. It is fundamentally about protecting our beneficiaries and ensuring we have the resources to provide for their care.

As part of our responsibility to taxpayers and beneficiaries to see that resources are used appropriately, CMS has an obligation to perform audits, medical review and use other oversight tools as a part of these efforts.

I would like to make three points today about the status of our efforts: First, we are having real impact in reducing waste, abuse and fraud in the Medicare program; second, we continuously work to reduce provider burden while meeting our obligations to the trust fund; and finally, we continue to improve and innovate to meet our mission.

On the first point, we're seeing success from our efforts to detect and prevent waste, abuse and fraud. Through medical review activities in fiscal 2013 alone, $5.6 billion in payments were prevented from being paid or were returned to the trust fund. We've saved an additional $7.5 billion over the last several years from payment edits, which prevent bad payments from being made in the first place. At the direction of Congress, CMS uses the recovery auditors to perform medical review to identify and correct Medicare improper payments. Recovery auditors have returned over $7 billion to the Medicare trust fund since the start of the national program in 2010.

Our anti-fraud activities have also had impact. Last year, HCFAC funding returned about $4 billion to the trust fund, resulting in an 8 to 1 return on investment. We have also revoked over 17,000 and deactivated over 260,000 providers and suppliers since passage of the Affordable Care Act. At the same time, we've recognized these efforts can impose burdens on providers.

CMS continually strives to carefully balance our responsibilities to protect the Medicare trust fund with our desire to limit the bur-

den these efforts can place. To that end, we use tools such as educational efforts, data transparency and significant contractor oversight to minimize burden wherever we can. We also engage in continuous dialogue with provider communities to improve our programs. As one example, during the next round of recovery audit contracting, CMS is making changes to the program based on feedback from stakeholders and we believe—that we believe will result in a more effective and efficient program with improved accuracy and more program transparency.

We have also utilized other approaches, such as prior authorization, to reduce improper payments, while granting more security and assurances to the provider community. We will continue to listen to stakeholders to make improvements to our programs.

Third, we appreciate this committee's interest in ensuring that CMS is improving its program integrity efforts and know that the Congress and the public expect real and tangible results. To that end, we are also looking to implement new authorities or improvements which can enhance our efforts and impact.

In July 2013, CMS imposed moratoria for the first time on the enrollment of certain types of new providers in geographic areas which have been prone to high amounts of fraud. With the moratoria in place, we've revoked the billing privileges of over 100 home health agencies in the Miami area and we've revoked an additional 179 ambulance suppliers in Texas. We are also continuing to work with law enforcement in these hotspot areas.

CMS is also using private sector tools and best practices to stop improper payments. Since June 2012, the fraud prevention system has supplied advanced analytics on all Medicare fee-for-service claims on streaming national basis. In its first year, the FPS stopped, prevented or identified over $100 million in improper payments, including savings from kicking out bad actors.

We've also begun to use the common private sector tool of prior authorization to address an area of high improper payments, the use of powered mobility devices. In 2012, CMS began a demonstration in seven States to require prior authorization. This demonstration has resulted in a significant decrease in expenditures, over 66 percent in the demonstration States and over 50 percent in the non-demonstration States.

Support from the provider community has been significant, many of whom have requested that CMS expand prior authorization to other parts of the country.

While we know that we have made progress to address areas of vulnerability, we also know that more work remains to further refine our efforts and prevent improper payments and fraud.

I look forward to answering the subcommittee's questions on how we can improve our commitment to protecting taxpayer and trust fund dollars while also protecting beneficiaries' access to high quality care. Thank you.

[Prepared statement of Dr. Agrawal follows:]

U.S. House Committee on Oversight & Government Reform
Subcommittee on Energy Policy, Health Care & Entitlements
Hearing on
CMS Efforts to Reduce Improper Payments in the Medicare Program
May 20, 2014

Chairman Lankford, Ranking Member Speier, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee' commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. We have made important strides in addressing improper payments and reducing waste, abuse and fraud across our programs and I appreciate the opportunity to discuss the priorities of CMS' Center for Program Integrity.

CMS is using a multi-faceted approach to target all causes of waste, abuse, and fraud that result in inappropriate payments by shifting towards prevention-oriented activities. We are working closely with law enforcement, states, private insurers, and providers in our efforts. CMS must strike an important balance while overseeing the Medicare program: limiting the administrative burden on legitimate providers and suppliers to preserve beneficiary access to necessary health care services while fulfilling our obligation to ensure taxpayer dollars are not lost to waste, abuse, and fraud. We have instituted many program improvements since the passage of the Affordable Care Act and other legislation, and are continuously looking for ways to refine and improve our program integrity activities.

In addition to CMS's ongoing program integrity efforts, the FY 2015 President's Budget reflects the Administration's commitment to strong program integrity initiatives, which includes investments that will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years. Such efforts targeting waste, abuse, and fraud have already helped extend the life of the Medicare Trust Fund, and are critical to protect Medicare for years to come.

Waste, abuse, and fraud can also inflict real harm on Medicare beneficiaries. Through prevention, we can decrease beneficiaries' exposure to risks and harm while preserving Trust

Fund dollars. For example, in the case of a Chicago-area dermatologist that was indicted in October 2012 for falsely diagnosing patients with skin cancer, patients endured the risks and trauma of unnecessary surgery. Using a proactive approach, CMS stopped payments to this provider in conjunction with law enforcement making the arrest and prosecuting the case.

Prevention

Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the Medicare program.

Strengthening Provider Enrollment

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. These new screening requirements resulted in an estimated additional 50,000 site visits, and in April 2014, CMS announced that upon notification, providers designated to the high screening level will be required to submit fingerprint-based background checks to gain or maintain billing privileges for Medicare.

The Affordable Care Act also required CMS to screen all existing 1.5 million Medicare suppliers and providers under the new screening requirements. Since March 25, 2011, more than 770,000 providers and suppliers have been subject to the new screening requirements and over 260,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of these screening efforts.[1] Since implementation of these requirements, CMS has also revoked 17,534 providers' and suppliers' ability to bill the Medicare program. These providers and suppliers were removed from the program because they had felony convictions,

[1] Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

were not operational at the address CMS had on file, or were not in compliance with CMS rules, such as licensure requirements.

Enrollment Moratoria

The Affordable Care Act also provides the Secretary the authority to temporarily pause the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In the last year, CMS has used this authority in seven metropolitan areas[2] to safeguard taxpayer dollars while ensuring patient access to care is not interrupted. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.[3] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.[4] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months.

In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of home health agencies and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. In Miami alone, CMS has revoked the billing privileges of 101 HHAs in 2013, with 67 revocations occurring after the moratorium was put into place. Additionally, law enforcement made arrests in a $48 million Miami home health

[2] The seven metropolitan areas where CMS has issued moratoria are: Miami, FL (Miami-Dade and Monroe Counties); Chicago, IL (Cook, DuPage, Kane, Lake, McHenry and Will Counties); Dallas, TX (Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant counties); Houston, TX (Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller Counties); Detroit, MI (Wayne, Macomb, Monroe, Oakland, and Washtenaw Counties); Philadelphia, PA (Philadelphia, Bucks, Delaware, and Montgomery Counties in Pennsylvania and Burlington, Camden, and Gloucester Counties in New Jersey); and Fort Lauderdale, FL (Broward County)

[3] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html

[4] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. In Texas, CMS has revoked the billing privileges of 179 ambulance companies in the last 12 months, and 92 revocations occurring after the moratorium was put into place in Houston.

Improper Payments in Medicare Fee-for-Service

Medicare fee-for-service has been deemed a "high risk" program by the Government Accountability Office in part due to the sheer size and complexity of the program. CMS pays 1.5 million providers for health care for 54 million beneficiaries under the Medicare program. The Office of Management and Budget has determined that Medicare is also a "high error" program due to its annual estimated error amount. Each year, CMS estimates the improper payment rate and a projected dollar amount of improper payments for Medicare, Medicaid, and CHIP.[5] While these improper payments represent a fraction of total CMS spending, any level of improper payment is unacceptable and we are working diligently to reduce these documentation, coding and claims processing errors.[6]

Improper payments are errors that are not necessarily fraudulent. The vast majority of Medicare FFS improper payments fall into two categories: 1) inadequate documentation to support the services billed and 2) the documentation as provided did not support that the services were medically necessary. Payments deemed "improper" under these circumstances tend to be the result of documentation and coding errors made by the provider as opposed to payments made for inappropriate claims. The most common error providers make is the failure to properly document the beneficiary's need for the service and most improper payments are made when information in the medical record did not support the services billed.

The factors contributing to improper payments are complex and vary from year to year. For example, a contributing factor to the FY 2013 Medicare FFS error rate was the implementation of new policies regarding documentation. Although the policy change will ultimately strengthen

[5] http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf
[6] The annual rates for all Federal programs that are deemed high-error are posted on the website www.paymentaccuracy.gov.

the integrity of the program, there is a change management aspect to implementing new policies. Since it takes time for providers and suppliers to fully implement new policies, especially those with new documentation requirements, it is not unusual to see changes in error rates following implementation of new policies.

CMS has designed its systems to detect anomalies on the face of the claims, and through these efforts, we are paying the claims correctly as they are submitted nearly 100 percent of the time. For example, CMS is using the National Correct Coding Initiative (NCCI) to stop claims that never should be paid in Medicare Part B and Medicaid. This program was first implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians.[7] In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program.[8] MUE edits prevent payments for services such as hysterectomy for a man or prostate exam for a woman. NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website.[9] The use of the NCCI procedure-to-procedure edits saved the Medicare program $530 million in FY 2013, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over $7.5 billion since 1996 based on savings reports from claims-processing contractors.

The main challenge with improper payments is that detection relies on evaluating the medical record – to identify whether the service was medically needed - for example – which is not submitted with claims. CMS and its Medicare Administrative Contractors (MACs) develop

[7] Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations.
[8] MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single data of service.
[9] Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities.

medical review strategies using the improper payment data to ensure that we target the areas of highest risk and exposure. The review strategies range from issuing comparative billing reports that educate providers about their billing practices by showing the provider in comparison to his or her state and national peers, to encourage providers to conduct self-audits, to targeted medical review of specific providers. The Medicare Administrative Contractors reported that medical review resulted in $5.6 billion in savings for FY 2013.[10]

Prior Authorization

One area that previously had high incidences of improper payments was the Powered Mobility Device (PMD) benefit; CMS found that over 80 percent of claims for motorized wheelchairs did not meet Medicare coverage requirements in 2011.[11]

As result of these and other findings showing very high improper payment rates for PMDs, CMS implemented the Medicare Prior Authorization of PMDs Demonstration in seven high risk states in September 2012.[12] Since implementation, CMS observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims submitted as of September 30, 2013, monthly expenditures for the PMDs included in the demonstration decreased from $20 million in September 2012 to $9 million in August 2013 in the non-demonstration states and from $12 million to $4 million in the demonstration states.[13]

We believe the decrease in overall spending is due in part to national Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers adjusting their billing practices nationwide (not just in the demonstration states) and reflects suppliers complying with CMS policies based on their experiences with prior authorization in the demonstration states.[14] The decrease in spending can also be attributed to the continuous DMEPOS supplier education

[10] http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf
[11] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf
[12] The seven states are: CA, IL, MI, NY, NC, FL and TX
[13] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf
[14] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf

and outreach mechanisms implemented by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and CMS as well as other initiatives to prevent fraud and reduce expenditures for medically unnecessary PMDs.

Additionally, overall the industry's feedback has been positive. Several DMEPOS suppliers have suggested prior authorization helps their business by providing a more predictable cash flow and improved relationships with the ordering physician. These suppliers have expressed support for the demonstration and would like it to be expanded to other states and items.

While the private sector widely uses prior authorization to control waste, abuse, and fraud, CMS is seeking authority to expand the use of this tool. The President's FY 2015 Budget includes a proposal that builds on the success of the Prior Authorization of PMDs Demonstration by giving CMS the authority to require prior authorization for all Medicare fee-for-service items, particularly those items at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure in advance that the correct payment goes to the right provider for the appropriate service, and preventing potential improper payments before they are made.

Fee-for-Service Recovery Auditors

CMS uses the Recovery Auditors to perform medical review to identify and correct Medicare improper payments primarily on a post payment basis. CMS uses the vulnerabilities identified by the Recovery Auditors to implement actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the first quarter of FY 2014, the Recovery Auditors have returned over $7.4 billion to the Medicare Trust Fund.

Recovery Audit Program Improvements

CMS is currently in the procurement process for the next round of Recovery Audit Program contracts and plans to award these contracts this year. In February 2014, CMS announced a number of changes to the Recovery Audit Program that will take effect with the new contract awards as a result of stakeholder feedback. CMS believes that improvements to the RAC

program will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.

Zone Program Integrity Contractors Reviews

Zone Program Integrity Contractors (ZPICs) identify providers that have aberrant billing patterns and other behaviors that are indicative of fraud. The ZPICs use medical review on a pre- and post-pay basis to identify medically unnecessary billed services. In addition, CMS, in coordination with its ZPICs, uses a variety of administrative actions to stop payments, including payment suspension or revocation of billing privileges when there is a credible allegation of fraud.

Fraud Prevention System (FPS)

Under the Small Business Jobs Act of 2010, CMS is required to use predictive modeling and other analytic technologies to identify and prevent waste, abuse, and fraud in our Medicare fee-for-service program. Since June 2011, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. CMS designed the FPS to accommodate different analytic model types to address a variety of fraud schemes. The most important indicator of success is that the models in the FPS have led to administrative action – we have used our revocation authority to remove bad actors from the Medicare program, which is the surest way to protect Trust Fund dollars and beneficiaries, suspended potentially fraudulent payments from going out the door, and referred leads and cases to law enforcement.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS First Implementation Year Report to Congress,[15] in its first year of implementation, the FPS stopped, prevented or identified an estimated $115.4 million in improper payments. These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the suspension of payments, and changes in behavior that result from CMS actions. The FPS

[15] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

achieved a positive return on investment, saving an estimated three dollars for every one dollar spent in the first year; and CMS is expanding the ways that we are using the FPS to identify bad actors and improper payments that will enhance its success. For example, CMS initiated a pilot project with one MAC to determine whether providers flagged by the FPS are appropriate targets for medical review and education. CMS found that the early education by the MACs changed about half of the providers' billing behavior, while others required increasing levels of intervention. CMS is also working to implement edits directly into the FPS that would stop payment based on Medicare payment policy. CMS is expanding both of these efforts in the FPS.

Collaborating with law enforcement

Earlier this year, the Government announced that in Fiscal Year (FY) 2013, its waste, abuse, and fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of $4.3 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.[16] Over the last five years, the Administration's enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period. Over the last three years, the average return on investment (ROI) of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997.

As a result of these and other efforts, there has been a measurable decrease in Medicare payments for certain medical services that have also been targeted by the Medicare Strike Force.

DME Competitive Bidding

Finally, on January 1, 2011, CMS implemented Round 1 of DME competitive bidding program in nine areas, including Miami and CMS implemented Round 2 of the program in 91 additional areas on July 1, 2013. It is projected to save the Medicare program approximately $27 billion and beneficiaries $18 billion over ten years.[17] The program works by establishing Medicare's DMEPOS payments based on competitive market pricing, thereby reducing beneficiary out-of-pocket costs, program outlays, and suppliers' incentive to fraudulently bill Medicare for

[16] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf
[17] FY 2015 Congressional Justification, Page 41.

DMEPOS. Moreover, CMS' monitoring revealed the competitive bidding program may have curbed previous inappropriate distribution of these supplies. Round 1 of the DME competitive bidding program is already generating significant savings for the Federal Government and the approximately 2.3 million Medicare fee-for-service beneficiaries residing in the areas where the Round 1 program is in effect. The competitive bidding program resulted in average savings of 35 percent below the fee schedule rates and saved more than $400 million in the first two years of operation while preserving beneficiary access to quality items in the nine Round 1 Rebid areas.[18] For the second round of the program, which started in July 2013, CMS is projecting savings of 45 percent below fee schedule prices for DMEPOS items, and savings for the national mail-order program are estimated at 72 percent below fee schedule prices.

Law enforcement activity combined with various measures taken by CMS, which themselves were prompted by enforcement activity, appear to have contributed to even further declines in Medicare payments for DME in Miami over time. Payments by Medicare for DME in Miami-Dade County alone hit an all-time high in the third-quarter of 2006, when payments exceeded $73 million, those payments have decreased over time, and in the first-quarter of 2013 payments were under $15 million.

Working Across the Health System

CMS is coordinating a variety of efforts with Federal and state partners, as well as the private sector to better share information to combat fraud. CMS issued new compliance program guidelines to assist Medicare Advantage plans and prescription drug plans design and implement a comprehensive plan to detect, correct and prevent waste, abuse, and fraud. CMS also enhanced its data analysis and improved coordination with law enforcement to get a more comprehensive view of activities in Medicare Advantage and Part D. The Part C and D program integrity contractor, the MEDIC, identified vulnerabilities and performed analysis that identified over $105 million in improper payments. The MEDIC then sent notification to plan sponsors to delete the records associated with improper payments from FYs 2011 and 2012. To increase the impact of the proactive analysis, CMS proposed a rule that would provide CMS, the MEDIC,

[18] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-10-31.html

and other agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies, and other downstream entities of Part D plans.

In July 2012, the Secretary of HHS and the Attorney General announced a historic partnership with the private sector to fight waste, abuse, and fraud across the health care system. The ultimate goal of the Healthcare Fraud Prevention Partnership (HFPP) is to exchange facts and information to identify trends and patterns that will uncover waste, abuse, and fraud that could not otherwise be identified. The HFPP currently has 36 partner organizations from the public and private sectors, law enforcement, and other organizations combatting waste, abuse, and fraud. In 2013 and 2014, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions such as payment system edits, revocations and payment suspensions to stop payments from going out the door and improve our collective forces against waste, abuse, and fraud. Just last week, the Secretary and Attorney General announced a nationwide takedown by Medicare Fraud Strike Force operations in six cities that resulted in charges against 90 individuals, including 27 doctors, nurses and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $260 million in false billings.[19]

Moving Forward

Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive, or fraudulent services. But the importance of program integrity efforts extends beyond dollars and health care cost alone. It is fundamentally about protecting our beneficiaries – our patients – and ensuring we have the resources to provide for their care. Although we have made significant progress by implementing important policies like prior authorization to prevent improper payments before they are made and utilizing technology and data to reduce coding errors and other billing anomalies, more work remains to be done.

[19] http://www.hhs.gov/news/press/2014pres/05/20140513b.html

Going forward, we must continue our efforts to move beyond "pay and chase" to prevent fraud before it happens, provide leadership and coordination to address these issues across the health care system, and ensure that we take administrative action as swiftly as possible to stop suspected instances of waste, abuse, and fraud. We share this Subcommittee's commitment to protecting taxpayer and trust fund dollars, while also protecting beneficiaries' access to care, and look forward to continuing this work.

Mr. LANKFORD. Mr. Ritchie.

STATEMENT OF BRIAN P. RITCHIE

Mr. RITCHIE. Good morning, Chairman Lankford, Ranking Member Grisham, and other distinguished members of the subcommittee. Thank you for the opportunity to discuss OIG's work on Medicare improper payments.

Improper payments cost taxpayers and Medicare beneficiaries about $50 billion a year. Recovering these lost dollars and preventing future improper payments is paramount. In short, more action is needed from CMS, its contractors and the Department. CMS needs to better ensure that Medicare makes accurate, appropriate payments. When improper payments do occur, CMS needs to identify and recover them.

It must also implement safeguards to stop additional overpayments. CMS relies on contractors for many of these vital functions. This means that ensuring effective contractor performance is essential.

Finally, the Medicare appeals system needs to be fundamentally changed to ensure efficient, effective and fair outcomes for the program, its beneficiaries and providers.

My written testimony elaborates on OIG's work and recommendations in all of these areas. This morning I'll focus on four key points that illustrate our work on these issues.

First, CMS must do a better job ensuring the payments are accurate. For example, CMS needs to better protect Medicare and beneficiaries from inappropriate prescribing and billing for drugs. This is both a safety issue and a financial issue. We've found that Part D paid millions of dollars for drugs prescribed by massage therapists, athletic trainers and others with no authority to prescribe. CMS is working toward implementing several OIG recommendations to tighten up monitoring of billing for drugs.

Second, when improper payments occur, CMS needs to do four things.

Mr. LANKFORD. Mr. Ritchie, you might check your microphone there to see if it—it clicked off. Is it still lit up there?

Mr. RITCHIE. Thanks.

Mr. LANKFORD. Okay.

Mr. RITCHIE. Second, when improper payments occur, CMS needs to do four things: Identify, recover, assess and address.

CMS contracts with recovery auditors, or RACs, to identify improper payments. In 2010 and 2011, RAC audits result the in more than $700 million in overpayments recovered. CMS also assesses the RAC findings to understand why the overpayments occurred. It then must address these issues to prevent future improper payments.

My third point is that CMS needs to better ensure that its contractors perform effectively. CMS contractors pay claims, identify and recover overpayments, and protect Medicare from fraud and abuse.

OIG has consistently raised concerns about contractor performance and oversight. CMS needs to assess performance more effectively and take action when contractors fail to meet standards.

And, finally, the Medicare appeals system needs to be fundamentally changed. Even before the recent surge in appeals and subsequent backlog, OIG raised concerns about the administrative law judge, or ALJ, level. ALJ's overturn prior level decisions more than half the time. ALJ's also vary widely amongst themselves in decision-making. This happens partly because Medicare policies are not clear. OIG recommends clarifying Medicare policies and then coordinating training on those policies at all levels of appeals.

Administrative inefficiencies also contribute to the problem. We recommend that paper files be standardized and made electronic.

In closing, more needs to be done to reduce and recover improper payments, ensure effective contractor performance, and improve the appeals process. OIG is committed to finding solutions to reduce waste, protect beneficiaries and improve the program.

Thank you for your time, and I welcome your questions.

[Prepared statement of Mr. Ritchie follows:]

Testimony of:
Brian P. Ritchie
Acting Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services
Hearing Title: "Medicare Mismanagement: Oversight of the Federal Government Efforts to Recapture Misspent Funds"
House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

Good morning, Chairman Lankford, Ranking Member Speier, and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's (OIG) recommendations to prevent Medicare improper payments, increase recoveries of overpayments, ensure effective performance by contractors, and improve the Medicare appeals process that resolves disputes over improper payments. Fighting waste, fraud, and abuse in Medicare is a top goal, and improper payments cost Medicare billions of dollars each year. Reducing this amount is paramount.

In short, more action is needed from the Centers for Medicare & Medicaid Services (CMS), its contractors, and the Department to achieve this goal. CMS needs to better ensure that Medicare makes accurate and appropriate payments. When improper payments do occur, CMS needs to identify and recover them. It must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve issues about improper payments efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

Overall, the Department has implemented many of OIG's recommendations, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In fiscal year (FY) 2013, OIG audits and investigations resulted in expected recoveries of $5.8 billion in stolen or misspent funds across Department programs. In addition, OIG reported estimated savings of more than $19 billion resulting from legislative and regulatory actions supported by OIG recommendations.[1] The Health Care Fraud and Abuse Control Program (a joint program of the Department, OIG, and the Department of Justice to fight waste, fraud, and abuse in Medicare and Medicaid) returned more than $8 for every $1 invested.[2]

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[1] Office of Inspector General's *Semiannual Report to Congress*, Fall 2013, available online at http://oig.hhs.gov/reports-and-publications/archives/semiannual/2013/SAR-F13-OS.pdf.

[2] The $8 to $1 return on investment is a three-year rolling average from FY 2010-2013. For more details on this and other HCFAC accomplishments, see the FY 2013 *Health Care Fraud and Abuse Control Program Report*, available online at http://oig.hhs.gov/reports-and-publications/hcfac/index.asp.

Despite these successes, further actions are needed to protect Medicare and Medicaid from waste, fraud, and abuse. In March 2014, OIG issued its *Compendium of Priority Recommendations*, which highlights additional opportunities for cost savings and program and quality improvements.[3] Implementing these recommendations could result in billions of additional dollars saved. My testimony today focuses on a selection of those key recommendations.

CMS Needs to Better Ensure that Medicare Makes Accurate and Appropriate Payments

Overall, improper Medicare payments cost taxpayers and beneficiaries about $50 billion a year.[4] Medicare fee for service, the largest program, reported an error rate of 10.1 percent ($36 billion) in FY 2013. OIG's audits and evaluations have identified opportunities to reduce Medicare improper payments for specific program areas and services. Examples of two critical areas include payments for prescription drugs and payments to home health agencies.

Better Protect Medicare and Beneficiaries from Inappropriate Prescribing, Use, and Billing for Prescription Drugs

OIG has extensively examined CMS's monitoring and oversight of the Part D program and the effectiveness of controls to ensure appropriate payment and patient safety. Our work has found limitations in program safeguards that leave Part D vulnerable to improper payments and Medicare patients vulnerable to potentially harmful prescribing. For example, we found that Medicare inappropriately paid millions of dollars for prescriptions from unauthorized prescribers, such as massage therapists and athletic trainers.[5]

Further, thousands of retail pharmacies demonstrated extremely high billing for at least one of the eight measures of questionable billing we developed (e.g., billing for very high numbers of prescriptions per Medicare patient).[6] For example, one pharmacy billed an average of 116 prescriptions per Medicare patient – almost 5 times the national average of 24 prescriptions per Medicare patient. Pharmacies with questionable billing could have billed for drugs that were not medically necessary or that were not provided to beneficiaries. We have also uncovered extreme prescribing patterns by hundreds of physicians (e.g., prescribing extremely high numbers of prescriptions per Medicare patient, relative to their peers).[7] For example, over 100 general-care

[3] Office of Inspector General's *Compendium of Priority Recommendations*, March 2014, available online at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

[4] *Department of Health and Human Services FY 2013 Agency Financial Report,* available online at http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf.

[5] *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 2013, available at http://oig.hhs.gov/oei/reports/oei-02-09-00608.asp.

[6] *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012, available at http://oig.hhs.gov/oei/reports/oei-02-09-00600.asp.

[7] *Prescribers With Questionable Patterns In Medicare Part D*, OEI-02-09-00603, June 2013, available at http://oig.hhs.gov/oei/reports/oei-02-09-00603.asp.

physicians prescribed at a rate of more than 70 prescriptions per Medicare patient. Nationally, general-care physicians average 13 prescriptions per Medicare patient. While questionable billing is not necessarily improper or fraudulent, it may be an indication of such and warrants further scrutiny.

These vulnerabilities are even more concerning in light of the increasing number of OIG investigations into prescription drug fraud. For example, a physician in Kansas and his wife ran a pill mill and wrote thousands of medically unnecessary prescriptions for narcotics. The physician was directly linked to the deaths of four patients, and he billed the drugs to Federal health care programs and private insurers for over $4 million dollars. Both the physician and his wife were sentenced to more than 30 years in prison.[8] The serious and growing problem of prescription drug abuse lends a greater urgency to efforts to address fraud and improve monitoring and oversight of Part D.[9]

Key OIG recommendations to CMS related to the issues described above include:

- require Part D plans to verify that prescribers have the authority to prescribe,
- instruct the Medicare program integrity contractor to expand its analysis of prescribers, and
- provide Part D plans with additional guidance on monitoring prescribing patterns.

CMS issued a proposed rule that would require all prescribers of Part D drugs to be enrolled in the Medicare fee-for-service program (or officially opt out).[10] If implemented, this requirement could help CMS, Part D plans, and the Medicare program integrity contractor enhance their monitoring and better prevent and detect Part D improper payments and potential fraud.

CMS Should Better Prevent, Identify, and Recover Improper Payments to Home Health Agencies

For decades, OIG has raised concerns about improper Medicare payments to and fraud committed by home health agencies. CMS has taken steps to protect against improper Medicare billing for home health services, but these actions have not fully addressed the problem.

For example, CMS implemented a requirement of the Affordable Care Act that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients. However, OIG found that almost one-third of home health services claims in 2011 and 2012 did not meet these requirements, resulting in $2 billion in

[8] U.S. Department of Justice Press Release, Jury: Haysville Doctor and Wife Guilty in Deadly Prescription Drug Overdoses, June 24, 2010, available online at http://www.justice.gov/usao/ks/PressReleases/2010/jun/June24a.html.

[9] See *Spotlight on Drug Diversion*, available at http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp.

[10] Federal Register, Volume 79, Number 7, pages 1982-1987, published January 10, 2014, available online at http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf.

improper payments.[11] Furthermore, CMS has struggled to collect all of the overpayments to home health agencies that it has identified and has not implemented a requirement promulgated in 1998 that home health agencies obtain surety bonds, which could aid in recouping some of these funds.[12]

In addition, OIG found that in 2010, one-quarter of home health agencies met the threshold of at least one of six questionable billing measures that we created (e.g., billing for unusually high numbers of visits per patient or average payment amounts per patient, relative to other home health agencies).[13] For example, 13 home health agencies billed for more than 300 visits per Medicare patient in 2010. In comparison, the median number of visits per Medicare patient across all Medicare home health agencies was only 32. Further, OIG investigations have uncovered significant home health fraud, including a case in Texas involving more than $300 million in alleged fraudulent Medicare billing.[14]

Key OIG recommendations to CMS related to improper payments for home health services include:

- create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements,
- implement the surety bond requirement for home health agencies, and
- increase monitoring of Medicare claims for home health services.

CMS Should Maximize Recovery of Improper Payments and Better Address Payment Vulnerabilities to Prevent Improper Payments

The ultimate goal is preventing improper payments entirely. However, the reality is that Medicare pays billions of dollars improperly each year. CMS must maximize the recovery of overpayments identified by its contractors and others. It is also paramount to prevent the recurrence of improper payments by identifying why they occurred and improving program safeguards accordingly.

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[11] *Limited Compliance with Medicare's Home Health Face to Face Documentation Requirements*, OEI-01-12-00390, April 2014, available online at http://oig.hhs.gov/oei/reports/oei-01-12-00390.asp.

[12] *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments*, OEI-03-12-00070, September 2012, available online at http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp.

[13] *Inappropriate and Questionable Billing by Medicare Home Health Agencies*, OEI-04-11-00240, August 2012, available online at http://oig.hhs.gov/oei/reports/oei-04-11-00240.asp.

[14] U.S. Department of Justice Press Release, *Dallas Doctor Arrested for Alleged Role in Nearly $375 Million Health Care Fraud Scheme*, February 28, 2012, available online at http://www.justice.gov/opa/pr/2012/February/12-crm-260.html.

Maximize Recovery of Overpayments

CMS's challenges in recovering overpayments are not limited to home health agencies. OIG examined overpayments in "currently not collectible" status – a classification that CMS uses for overpayments in which the provider has not made a repayment for at least six months.[15] In FY 2010, CMS reported that $543 million in overpayments had been newly designated as "currently not collectible." However, CMS had limited information to track most of these overpayments in its accounting system. For those it did track, virtually all went uncollected. According to contractors, inaccurate provider contact information delays or prevents some overpayment-demand letters from reaching providers. Expanding the types of provider identifiers used to offset overpayment could improve debt recovery efforts, particularly for providers with multiple Medicare national provider identifiers.

These challenges echo earlier OIG findings that the vast majority of overpayments identified by CMS's program integrity contractors went uncollected. Further, CMS did not adequately track information on these overpayments and their collection status.[16]

CMS contracts with Recovery Auditors (RACs) to identify Medicare improper payments for recovery (in cases of Medicare overpayments) or return (in cases of Medicare underpayments). OIG reviewed the RAC program for the Medicare fee-for-service program in 2010 and 2011.[17]

RACs audits identified improper payments totaling $1.3 billion in FYs 2010 and 2011. These audits resulted in about $768 million recovered from providers and about $135 million in payments returned to providers.

Better Address Vulnerabilities to Prevent Improper Payments

In addition to recovering overpayments, CMS uses RAC audits to identify vulnerabilities and develop corrective action plans to prevent future improper payments. Vulnerabilities have included, for example, billing for services or supplies on behalf of deceased beneficiaries. By June 2012, CMS reported that it had taken corrective actions to address most of the vulnerabilities it had identified from the 2010 and 2011 RAC audits. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, a key step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

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[15] *Medicare's Currently Not Collectible Overpayments*, OEI-03-11-00670, June 2013, available online at http://oig.hhs.gov/oei/reports/oei-03-11-00670.pdf.

[16] *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010, available online at http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf.

[17] *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, September 2013, available online at http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf.

CMS has missed opportunities to address improper payment vulnerabilities identified by its program integrity contractors. In 2011, OIG found that CMS had resolved or taken significant action on only about a quarter of the vulnerabilities that its program integrity contractors had reported in 2009.[18]

Key OIG recommendations to CMS to maximize recovery of improper payments and address payment vulnerabilities include:

- improve tracking and monitor the status of overpayment collections,
- expand the types of provider identifiers used to recover overpayments,
- address program vulnerabilities identified by contractors in a timely manner, and
- evaluate the effectiveness of corrective actions.

CMS Needs to Ensure Effective Performance by Its Contractors

CMS relies on contractors to operate vital functions of the Medicare program, including paying claims, running program integrity activities, identifying overpayments, and recouping overpayments. CMS contracts with Medicare Administrative Contractors (MACs) to process claims and implement payment safeguards; program integrity contractors, including the Medicare Drug Integrity Contractor (MEDIC), Zone Program Integrity Contractors (ZPICs), and Program Safeguard Contractors (PSCs), to protect Medicare from fraud and abuse; and RACs to identify and collect overpayments. OIG reviews of these contractors over the past decade have consistently identified problems, including failure to use data to assess contractor performance and inadequate response when contractors do not meet performance standards.[19]

Use Data More Effectively to Oversee Contractor Performance and Include Key Metrics in Performance Evaluations

Program integrity contractors are required to periodically report to CMS data describing their activities. However, OIG found that the data used by CMS to oversee ZPICs were not accurate or uniform, preventing a conclusive assessment of contractor activities. Further, OIG found significant differences in fraud detection efforts across ZPICs (and in earlier work, across PSCs) that could not be explained by differences in budget or oversight responsibility. Yet, CMS had not assessed the wide variation across contractors' activity data, and CMS contractor

[18] *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500, December 2011, available online at http://oig.hhs.gov/oei/reports/oei-03-10-00500.asp.

[19] Findings and recommendations from a series of OIG evaluations of contractor oversight and performance are summarized and referenced in OIG's *Compendium of Priority Recommendations*, March 2014, available online at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

performance evaluations provide few quantitative details about the contractors' achievements in detecting and deterring fraud and abuse.[20]

Additionally, CMS's performance evaluations for RACs lacked metrics related to key contract requirements, such as identification of improper payments. In response to our report, CMS noted that it has revised its RAC evaluations to incorporate metrics on identification of improper payments and accuracy rates and is considering additional performance measures. We encourage CMS to continue to increase its use of performance metrics and data to oversee contractor performance.[21]

Evaluate Contractor Performance in a Timely Manner and Respond More Effectively When Performance Requirements Go Unmet

OIG found that CMS conducts extensive activities to review MACs' performance. However, the reviews are not always conducted in time to inform future contract award decisions. Further, CMS did not ensure that its MACs resolved or developed action plans to address unmet quality assurance standards.[22]

Key OIG recommendations to CMS related to contractor performance include:

- improve and more effectively use data to assess contractor performance, including to analyze performance across contractors and assess the causes of variation;
- strengthen performance evaluations and include key metrics to assess how well contractors are performing core functions; and
- conduct performance evaluations in a timely manner and address unmet performance standards more effectively.

The Medicare Appeals System Needs Fundamental Changes

Medicare appeals decisions affect providers, beneficiaries, and the program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

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[20] *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011, available online at http://oig.hhs.gov/oei/reports/oei-03-09-00520.asp.

[21] *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, August 2013, available online at http://oig.hhs.gov/oei/reports/oei-04-11-00680.asp.

[22] *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, January 2014, available online at http://oig.hhs.gov/oei/reports/oei-03-11-00740.asp.

In recent years, the system has experienced an unprecedented surge of appeals.[23] According to the Office of Medicare Hearings and Appeals (OMHA), from FY 2012 to 2013, the number of appeals reaching the Administrative Law Judges (ALJ, the third level of appeals) doubled.[24] OMHA estimates that its backlog will reach a million claims by the end of this fiscal year. A concerted effort by all key players—including CMS, OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

Before the recent surge, OIG completed work that focused on the ALJ level of appeals.[25] Although the work covered FY 2010, many of the findings and recommendations are relevant to understanding and addressing the current challenges.

A small percentage of providers account for a large number of appeals

Medicare providers make up the vast majority – 85 percent – of appellants. Moreover, only 2 percent of providers accounted for nearly one-third of all ALJ appeals. Specifically, 96 providers filed at least 50 appeals each with 1 provider filing over 1,000 appeals. ALJ staff has raised concerns that some providers appeal every payment denial and may have incentives to appeal because the cost is minimal and a favorable decision for the appellant is likely.

For more than half of appeals, ALJs decided fully in favor of appellants

In 2010, ALJs reversed prior-level decisions and decided fully in favor of appellants for 56 percent of appeals. In comparison, Qualified Independent Contractors (QICs) – the second level of appeals – decided fully in favor of appellants for only 20 percent of appeals. Appellants were most likely to receive favorable ALJ decisions for Part A hospital appeals (72 percent) and least likely for Parts C and D appeals (18 percent and 19 percent, respectively).

Differences between ALJ and prior-level decisions were due to different interpretations of Medicare policies and other factors

Several factors led to ALJs reaching different decisions than those in the prior level of appeals. We found that ALJs tended to interpret Medicare policies less strictly than did QICs. QICs also tend to be more specialized in Medicare program areas than ALJs and have clinicians on staff; ALJs tend to rely on evidence and testimony from the treating physicians. Both QIC and ALJ staff noted that lack of clarity in some Medicare policies is also a factor in the differing decisions.

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[23] OIG found that Medicare redeterminations – the first level in the Medicare appeals process – increased by 33 percent from 2008 to 2012. Increases in appeals by Part A providers related to RAC audits was one driver of the increase. See *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness*, OEI-01-12-00150, October 2013, available online at http://oig.hhs.gov/oei/reports/oei-01-12-00150.asp.

[24] Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015*, available online at http://www.hhs.gov/budget/fy2015/fy-2015-hhs-congressional-budget-justification.pdf.

[25] *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012, available online at https://oig.hhs.gov/oei/reports/oei-02-10-00340.asp.

Further, ALJs vary amongst themselves in decision-making. The fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs.

CMS participation affects the outcome of appeals

CMS participated in 10 percent of ALJ appeals in FY 2010. For those in which CMS participated, the ALJs were less likely to decide fully in favor of the appellant.

Current practices regarding appeals documents are highly inefficient

Both CMS and ALJ staff identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case file at the QIC level, creating inefficiencies in the appeals system. Because the QICs' case files are almost entirely electronic and ALJs primarily accept only paper case files, the QICs must convert the files to paper format before sending to the ALJs. Most staff noted that this process is resource intensive and prone to error.

Key recommendations to OMHA and CMS related to improving the appeals process include:

- identify and clarify Medicare policies that are being interpreted differently and develop and coordinate training on those policies;
- standardize case files and make them electronic;
- continue to increase CMS participation in ALJ appeals; and
- implement a quality assurance process to review ALJ decisions.

OIG Will Continue Working to Prevent and Recover Medicare Improper Payments

Reducing Medicare improper payments and ensuring effective program administration requires a concerted effort by a number of key players, including the Department, CMS, CMS contractors, providers, Congress, and OIG.

More action is needed to ensure that payments are made accurately. Any improper payments that do occur must be identified and recovered, and solutions must be identified and implemented to prevent recurrence. As CMS relies on contractors for most of these crucial functions, oversight of and accountability for contractor performance is paramount. Finally, the Medicare appeals system to resolve issues about improper payments must operate efficiently, effectively, and fairly.

While CMS has taken some important steps to identify and recover improper payments and implement safeguards to prevent them, our work demonstrates that further improvements are

needed. A comprehensive list of OIG's priority recommendations can be found in our *Compendium of Priority Recommendations* on our Web site.[26]

OIG will continue to audit and evaluate Medicare payments and vulnerabilities and recommend solutions to reduce the billions of dollars wasted each year. We are challenged in meeting this mission by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. By the end of this fiscal year, we expect to reduce our Medicare and Medicaid oversight by about 20 percent. Yet the Department estimated that Medicare and Medicaid outlays would grow by about 20 percent from 2012 to 2014. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect the Medicare and Medicaid programs, beneficiaries, and taxpayers.

We are committed to strong oversight of Medicare to reduce waste, fraud and abuse as comprehensively and effectively as possible with the tools and resources we have available. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries.

Thank you for your interest and support and for the opportunity to discuss some of our work related to Medicare oversight. I am happy to answer any questions you may have.

[26] Available at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

Mr. LANKFORD. Thank you all. I recognize myself for 5 minutes for opening—for a first round of questioning, and then we'll just go back and forth along the dais here.

Let me set some context for my time that's here. If a provider will have something reviewed—let's talk through the process and let's set context for everyone on this. Go back to Ms. Lujan Grisham's statement about the pay and chase side of this. So this is the post-payment has occurred. How will someone find out that they're going to be checked, inspected, whatever it may be, post-payment for any kind of claim? What's the step one? How would they be notified?

Ms. KING. They get a letter from a contractor.

Mr. LANKFORD. Okay. They get a letter from a contractor; that being with a RAC audit contractor, or that would be who?

Ms. KING. It could be one of four types of contractors. It would be MAC, a Medicare administrative contractor; it could be a BRAC; it could be the CERT contractor, who—which pulls a sample of random claims to estimate the improper payment rate; or it could be a ZPIC, a zone program integrity contractor, who is looking specifically for potential fraud.

Mr. LANKFORD. Okay. So let's back up. Let's take a specific—let's take a physical therapy clinic, stand-alone, privately-owned clinic seeing patients, a mixture of the insurance, private pay and then also Medicare. Okay. So that—you're saying that one physical therapy clinic could receive a request to pull a file from any one of those four, or those four are unique four different entities?

Ms. KING. They are—they could receive a request from any one of the four.

Mr. LANKFORD. Okay. Is it possible that all four of them will make requests during the course of a year to pull a file?

Ms. KING. It's not supposed to happen.

Mr. LANKFORD. Is it possible?

Ms. KING. Theoretically, but highly unlikely.

Mr. LANKFORD. Okay. So how are they notified, then, if one of them does it, or could two of them do it in the course of a year or could three? You're saying all four, unlikely.

Ms. KING. The RACs are not supposed to duplicate reviews that have been done by other contractors.

Mr. LANKFORD. Now, to the same provider or to the same case?

Ms. KING. To the same case.

Mr. LANKFORD. Okay.

Ms. KING. Unless——

Mr. LANKFORD. So it could——

Ms. KING. A duplicate claim is considered to be the same file for the same service.

Mr. LANKFORD. Could a provider get a review from all four of those different folks, different cases, but that provider itself get reviews from four different groups of people from Medicare during the course——

Ms. KING. It's possible, but it's unlikely.

Mr. LANKFORD. Okay. So what about from two of those or three of those? You're saying four is unlikely. Is it possible from them to get two of them?

Ms. KING. Yes. Like, for example, they might get a review from a RAC and they also might get a review from a CERT, who's estimating the improper payment rate.

Mr. LANKFORD. Okay. So when a RAC contacts them, how many are they pulling? How many files are they pulling at that point? Are they pulling one or are they pulling a sampling? How many are they going to pull?

Ms. KING. If they—they're pulling one, I believe. You know, overall, the RACs did over a million reviews.

Mr. LANKFORD. Correct.

Ms. KING. But when they're reviewing, they—you know, for a provider, they're pulling for that service.

Mr. LANKFORD. Right. But they're pulling—go back to our physical therapy clinic as well.

Ms. KING. Yeah.

Mr. LANKFORD. They're not going to reach in and just randomly grab one case, are they? Are they going to grab a sampling of cases for them to be able to review?

Ms. KING. No. I don't believe so.

Mr. LANKFORD. So how do they——

Ms. KING. I mean, that——

Mr. LANKFORD. How do they select which—which patient's file to review?

Ms. KING. Well, in the case of a RAC, CMS tells the RAC what kinds of issues they can look at. They work together with CMS, and CMS approves the type of issues that RACs are going to investigate.

Mr. LANKFORD. So they go and make the request of a certain type——

Ms. KING. Yes.

Mr. LANKFORD. —of client that's there. But I'm saying, they're not just pulling one patient, are they, from that type? They may pull 10, they may pull 20? How many do they pull?

Ms. KING. No. I believe the claims are investigated on an individual basis.

Mr. LANKFORD. Right, but the provider, I'm saying to the provider, when they get notification from the RAC.

Ms. KING. Yes. They'll get notification of a claim, investigation of a claim.

I'm sorry. Correction. There could be more than one, but there is a limit——

Mr. LANKFORD. Right.

Ms. KING. —on the number——

Mr. LANKFORD. That's what I'm tying get, is what is that limit, how many are they trying to pull? Does anyone else know the number on that? How many they're trying to pull at one time for a RAC audit?

Dr. AGRAWAL. So if I might, Congressman, just take a little bit of a step back, because I agree that there are numerous contractors that can audit a single provider. Each of those contractors actually has—you know, they are set in statute, they are supposed to do the job that they're doing.

Mr. LANKFORD. Right.

Dr. AGRAWAL. The CERT contractor's function is different from the RAC contractor. The CERT contractor's function is to go in there and actually determine the improper payment rate. It's not primarily looking at the provider. It, of course, has to do the medical record audit to determine whether or not an improper payment has occurred, but it's actually a function to evaluate our services.

So while I agree that numerous contractors can touch providers, we also do try to coordinate not touching the same claim or not such the same provider too often.

In answer to your last question, we have set limits for RAC contractors so that they can touch a provider and request a particular sampling based on the size of the provider themselves.

Mr. LANKFORD. Right. So how large is that sampling?

Dr. AGRAWAL. So just a hypothetical example might be a smaller provider that sends in, say, 10,000 claims a year, a RAC would be permitted to—to obtain no more than 20 to 25 claims at a time and no more frequently than, I believe, every 45 days.

Mr. LANKFORD. So they could come in every 45 days and pull 20 to 25, correct, different files and say we're not going to pay these until we get a chance to check them, correct, not correct?

Dr. AGRAWAL. I think conceivably that's correct, but, again, we do provide oversight to ensure that, you know, we are not burdening individual providers or individual entities during the course of these processes.

Mr. LANKFORD. Okay. I've exceeded my time. We'll come back to that. I want to honor everyone's time.

I do want to come back to that statement that we're not burdening individual providers. I could name you several dozen individual providers in my district that would beg to differ on that statement.

Now, you will find no greater advocates for the taxpayers and going after fraud than us at this panel, but we're also advocates to make sure that we don't lose providers, that our seniors still have access to multiple providers out there, that there aren't providers that say this is not worth it and drop out, I won't take Medicare anymore, because it's become so burdensome for them. So we've got to be able to do that.

With that, I recognize Ms. Lujan Grisham.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman.

And I'm going to do a couple of things, assuming I don't run out of time. I want to follow up on a couple of things that Chairman Lankford said. That balance is really tricky, and given that this committee clearly wants to focus on waste, fraud and abuse, even if the Medicare program and every other health care program was flush and that wasn't our being efficient and worrying about having services available for a growing population, you know, our job is to make sure that every tax dollar is being used the way it was intended, and we want bad actors and bad providers barred from this system and all others, no question about that. We also recognize that you have to do a due process system, and we appreciate that, but the due process system is clearly broken, because if you're waiting years for—and without payment, or having a payment removed, that's not due process. And I would agree, too, that we've created a very burdensome administrative environment. It's not

just the Federal touches for the Medicare program, although that is federally operated. Remember that most of these programs take Medicare, Medicaid, they're serving dual eligibles. They're being touched, reviewed, audited, administratively regulated by States, and some States with a whole different variety of private entities. So these small, sometimes small providers are spending an incredible amount of time being administratively reviewed. And these recovery audits, given that there is a contingency fee where they're being incentivized to identify issues and problems, this creates a pretty ripe environment for what I think you have today, which is we've now—with the Office of Medicare Hearings and Appeals, we've recently announced that we're going to suspend the ability of providers to have their appeals heard by administrative law judges.

The decision is made as a result of a massive backlog of appeals waiting an ALJ hearing, which by the Medicare Hearings and Appeals' own admission has grown from 92,000 to over 460,000 in just 2 years.

Now, Dr. Agrawal, I understand that the Office of Medicare Hearing and Appeals is not part of CMS. I also understand that your office oversees these contractors, including the RACs, whose audits are the cause of many, if not most, of these appeals.

Given the long wait times for getting an appeal heard by—wouldn't it would be prudent for CMS to suspend RAC audits until the claims backlog is cleared? And I want you to touch, Dr. Agrawal, on the fact that there are other ways to make sure that we are preventing fraud more than just the RAC audits.

Dr. AGRAWAL. Sure. Thank you. So I—I would start at just agreeing with you that it is a real challenge in program integrity to make sure that we are doing our job protecting the trust fund, and at the same time, doing as much as we can to lower the burden on providers and make sure that there are no access to care issues for our beneficiaries. That is a top priority, it's something I said in my opening statement.

I think it's also important to kind of level set a little bit on the amount of burden that we are placing on the system through our activities. As pointed out earlier by Ms. King, we audit far less than 1 percent of the claims that we receive. With respect to RACs in particular, you know, there are clearly appeals that occur from RAC audits, but the overall rate of appeals from overdeterminations—I'm sorry—the over—the overturn rate from all of the overdeterminations is about 7 percent. That's in the latest publicly available data.

If you look at just appeals that are initiated after an overpayment determination by a RAC, there's—the overpayment rate is about 14 percent out of all appeals that are generated.

So I do think that the appeals process is important for providers. It allows them an opportunity to represent their claims, to represent their interests, and it provides an important check and balance on our approach.

As far as the third level of appeal that involves the ALJ, as you pointed out, that is not directly under our control. We have been working with the Department to devise strategies for that backlog.

Well, what is directly under our control are the first two levels of appeal, and I can tell you that both the overturn rate is not sub-

stantially high in those areas, and they are being—and the appeals are being heard in a timely fashion. There are other—numerous other kind of strategies that we've taken to try to decrease the appeals. I want to afford you your time, so I'm happy to go into them if you'd like.

Ms. LUJAN GRISHAM. And I just want to—and I appreciate that, except that I would certainly make the statement that, and you've heard this, or heard this theme, I think, throughout this hearing, we have providers who would differ with you about these administrative burdens and whether 14 percent is reasonable in terms of what they can manage in terms of cash flow for their patients and staff.

And I would also say that many of the smaller providers couldn't afford to appeal, so I'm not sure if this data is really relevant, and what strategies have you undertaken to identify how many providers certainly come to me, those providers, who would love to appeal, because they believe that they've been wronged or there has been an administrative error, but don't have the ability to do that. Also, I would say fear, intimidation and retaliation, and just pay or do whatever it is that they're asked to do at the next level.

And I'm way over time, so if you could respond to that, and then I'll come back.

Dr. AGRAWAL. Sure. In addition to appeals, Congresswoman, there are other controls that we have implemented over our contractors. We do determine what areas RACs can look at. They have to achieve—sort of get permission from our board at CMS before they enter into any particular audit area. That is a type of oversight.

We have an independent validation contractor that looks behind the RACs themselves to evaluate whether or not they are making these determinations accurately. And all of the RACs have, through that validation contractor, achieved well over 90 percent accuracy rate.

I think the incentive structure itself actually incentivizes getting it right. So, you know, RACs do get paid on a contingency basis, as you pointed out, but if they lose on appeal, they lose the contingency fee. I think that is an enormous incentive on the RACs to make sure that they're making the right determinations in the first place.

And let me correct just one factual issue. I said it was a 14 percent overturn rate overall. This is in Part A, since a lot of—a lot of our issues you identified were in Part A.

Ms. LUJAN GRISHAM. And, Mr. Chairman, if I can, so the answer is, however, we don't know how many providers are unable to appeal, and there's no test to determine—I mean, you have one side of the data equation, and I'm not sure that that's an accurate representation as a result. So I appreciate that you're looking at these tests.

And I'll yield back, Mr. Chairman, but I'd like to explore that further.

Mr. LANKFORD. Great. We will on the second round. Before I yield to Mr. Gosar, let me just make one quick statement to Dr. Agrawal as well. You mentioned that there is a—the incentive for RACs to be able to limit that, because they lose their contingency

fee if they lose on appeal. The problem with that is, a fishing illustration. Let me give you an Oklahoma illustration. If you're fishing, you can put one hook in the water or you can put five hooks in the water, and you may only catch one fish, but you're going to catch more more often.

And if a RAC decides they're going to try to just grab 20 different cases and they hope that they win 10 of them, that's better than just grabbing 10 of them. And if it's close, go ahead and just grab that file and keep moving from there, and we may win it, we may not win it. That's helpful to the RAC in their contingency fee. That's definitely not helpful to the provider to then have to go through all the process. And we can talk about that more in just a little bit.

With that, I recognize Dr. Gosar.

Mr. GOSAR. Thank you very much, Mr. Chairman.

You know, while you were on that frame of thought, do you have any differentiation in your facts in regards to small providers, large providers and their overturn rates?

Dr. AGRAWAL. I don't think the data differentiates it in terms of the appeals data. I'm not aware of data that differentiates between small and large. I think the point I made earlier is that we do have different requirements of the contractors when they look to audit a smaller provider versus a larger one. There is different medical record request requirements to make sure—again, to try to limit that burden that is being placed, especially on the smaller providers.

Mr. GOSAR. It would be very interesting to know. Particularly, I represent rural Arizona, and so I would like to see some type of movement to try to make that accountable.

You know, when you say the overturn rate, you know, with Part A, what about Part B?

Dr. AGRAWAL. You know, I am actually not aware of—I don't have the figure in front of me. We can actually connect with your office, if that's okay, to get you a Part B overturn rate.

Mr. GOSAR. I think that's very, very important just because most of those Part B aspects are actually institutions, not individual providers. Would you agree?

Dr. AGRAWAL. I think the Part—let me just make sure I heard you correct, sir. I believe the Part A claims are the ones that tend to be more institutional, the hospitals, and then the Part B claims can tend to be individual providers or groups of providers.

Mr. GOSAR. Okay. Ms. King, from your oversight aspect, do you see maybe a change that you would recommend for methodology instead of, you know, looking at a provider as being guilty in an aspect, kind of an atmosphere like that? Do you see a better way of handling this?

Ms. KING. I don't actually think that the—that the post-payment review starts off with the provider is guilty. I think it's not—it's not a criminal matter. It's a matter of either an overpayment or an underpayment. And I do think that CMS has a responsibility, as stewards of the trust funds, to make sure that claims are paid properly, and as part of that, I think they need to do as much as they can effectively on the pre-payment side, but I also think that they need to look at the post-payment side.

That being said, we have found some instances in which the requirements are posing administrative burdens on providers, and we have recommended that CMS reduce, not the requirements, but the differences across contractors so that providers have a better understanding of what they're required to do.

Mr. GOSAR. From the standpoint of that process, Dr. Agrawal, is there a way that we could actually identify maybe frequent fliers? Do we have a frequent flier list? I mean, State boards kind of do this. I mean, we're kind of replicating something that State boards do.

Dr. AGRAWAL. Well, I think we take a different approach. So, you know, the spectrum of program integrity is long, and there are folks on one side that are totally legitimate providers that are trying to abide by our rules that are honest, and they are the vast majority of providers. On the other side, a much smaller subset are potential criminals, or people that are perhaps trying to rob the program.

So we do take—you know, I would argue that the various approaches that we have to oversee the program integrity issues do try to take into account where our risk really lies. And I think part of why we can take an audit-based or post-pay approach for the vast majority of providers is because they are legitimate and an audit is a reasonable approach for them.

We do take a much more kind of risk-based approach on the fraud side that really can ratchet up the intensity of how we look at a provider based on findings from audits. I think that's really appropriate for providers that are pushing the line, potentially even committing, you know, criminal activities.

We try on the other side of the house to take a much more fact-based approach. We look at issues that are big national issues where we know that are improper payments and then, you know, we'll do deeper analyses to determine which providers to look at, but it tends to be focused on where our improper payments are occurring. It isn't sort of a ratcheting up on a single provider.

Mr. GOSAR. But wouldn't it would be more efficient in regards to looking at the profile—having some type of a profiling aspect? You know, in State boards, I mean, you have a list. Most of your problems are with 10 percent of the population.

Dr. AGRAWAL. Right. And I think the comparison to States boards, I mean, I would just remind you that State boards are often dealing with the most difficult of cases, they're the ones on the right side of the house where, you know, these are providers that are committing potentially criminal or negligent activities, so they are dealing with probably the worst or—the worst actors.

Again, we do do that with a similar set of actors. I think what we are looking at perhaps, and again, to try to decrease the potential burden from these audits is not ratcheting up, but perhaps looking at solutions that might ratchet down. So as providers get audited and it turns out that their claims are substantiated, that there are not a lot of errors, we can perhaps audit them less. That's a solution that, for example, we're looking into to see if we can implement it.

Mr. GOSAR. Gotcha. Thank you, Mr. Chairman.

Mr. LANKFORD. Can I just follow up on that as well? As of when? When will that occur? Because that is one of the recommendations that hovers out there. How does someone prove basically I'm a good actor, and they don't get someone constantly coming in to check them all the time?

Dr. AGRAWAL. I think there are a number of solutions that we're looking at. As I think somebody pointed out earlier, the RAC program is currently in a pause state, where we are actually working on the next round of procurements. As part of that procurement activities, we are looking at the statement of work, taking into account a lot of opinions and input that we've gotten from stakeholders, including providers, and are trying to solution how RACs can still do their jobs, still meet our obligations, but try to decrease that burden, and that's one of many solutions we're considering.

Mr. LANKFORD. Okay. Let me come back. When?

Dr. AGRAWAL. I couldn't promise you an exact date.

Mr. LANKFORD. Is that something that providers, they can think about for next year? Is that 2 years? Is that 10 years from now?

Dr. AGRAWAL. Well, I think we are working on the procurement now and we hope to complete it some time in the next few months, and so it'll be—I think it remains to be seen if that's a change that can be pursued in the near term or potentially——

Mr. LANKFORD. That change is still under discussion. That's not a definite—that's under discussion at this point to try to figure out, I've got a good actor there, as Dr. Gosar mentioned.

Dr. AGRAWAL. Yeah. It's one of many solutions that we are looking at. Again, we've heard a lot of input from the provider community, and we are trying to take action where we can.

Mr. LANKFORD. All right. We'll come back to that.

Mr. Horsford.

Mr. HORSFORD. Thank you very much, Mr. Chairman.

Listening this morning, it gets a little frustrating when we're up here, because it seems like despite the fact that we all come from different communities and are sharing very clear examples of why the approach that's being taken isn't working, we continue to get pushback and basically reiterating the same points without any clear determination of when things will improve.

And on behalf of the constituents I represent in Nevada, Medicare is vitally important to their quality of life. I'm talking about the beneficiaries here. And when someone who is Medicare eligible can't see an OB/GYN in my community because there are no providers who will accept them, because of issues ranging from the reimbursement rate, to the delay in being paid for services rendered, to other compliance issues, it makes me want to know what can we do now in the short term to be able to move this forward.

You know, Medicare is a bedrock of our programs. People rely on these services. We have providers who about a third or more of their patients are typically Medicare covered. And as my colleague, Ms. Grisham explained, it also typically includes Medicaid or other pay sources as well, and so when you layer that burden on the provider, it's tough to provide services. That's what we're hearing.

So after speaking to several stakeholders in Nevada, particularly hospitals and medical providers all around the Las Vegas Valley, and I also include some of the rural counties in Nevada, which are

woefully underserved by enough providers, the accountability of the recovery audit contractor program seems questionable at best, and I don't understand how you continue something that doesn't even—hasn't even been properly evaluated.

While these programs have a noteworthy mission of seeking out improper payments of Medicare services, it seems there are potentially perverse incentives to these RACs. In 2010, the RAC program was expanded to all 50 States and made permanent. Now, again, I don't know how you start something, don't evaluate it, and then expand it to 50 States, first of all.

In 2013, over 192,000 claims were filed by these auditors to the Office of Medicare Hearings and Appeals, contributing to a backlog of over 357,000 claims. The recovery audit contractor program, as I said, may have been well intentioned, but there have been unintended consequences.

So, Acting Deputy Inspector Ritchie, in your testimony, you include a long list of policy recommendations for CMS to address. You reported that 72 percent of denied hospital claims at the third level of adjudication are overturned ultimately in favor of the hospitals. What recommendations have you offered CMS and this committee to address the concerns that RACs are not—no pun intended, dramatically racking up the number of claims backlog?

Mr. RITCHIE. Thanks. I think first we've offered recommendations both in the RAC area and in the appeals area. I think it's important, while they're so intertwined, to consider those separate in some ways, too.

In our RAC work, it was—all the work that we have—that we're talking about was before this current backlog, but we've see things that we still think are relevant. In the RAC work, we did see in 2010 and 2011 that they weren't helping—as I mentioned in my testimony. We need to make appropriate payments, and when inappropriate payments are made, they need to be recovered. Only—they did recover $1.3 billion in 2010 and 2011, and 6 percent of them were appealed. Now, when they're appealed, there's a very high overturn rate, so clearly something needs to be done.

I'd point to our ALJ work for the recommendations I'd push to the most, because for the system to really work and where the backlog is, we think the biggest recommendation that we had is these Medicare policies are not clear. And I think, you know, all fraud is certainly improper payments, but all improper payments are not fraud. And most of these providers are not committing fraud; they just don't understand the complex system and they're trying to submit claims that's complicated.

Then we saw in our ALJ work that 56 percent of the ALJ's overturned 20 percent of the QICs that the prior level overturned, and a lot of that was just due to different interpretations of the policies, different stuff that they were doing there, so our——

Mr. HORSFORD. Is there a set of recommendations dealing with the Medicare policies?

Mr. RITCHIE. Yeah. Our recommend—in our recommendations, because there are so many, it's mainly to clarify, select the policies that need to be clarified, clarify those, and then educate people on the policies to create less overpayments, less appeals in the process. For instance, in my written testimony, I talk about our home

health work. We found with the recent face-to-face requirement that if a physician is certifying that you're eligible for home health, they have to have a face-to-face encounter. We found $2 billion in improper payments in 2011 and 2012 and a third of the claims didn't meet the requirement.

Now, we don't think a third of the claims were fraudulent. It's because these are complex policies. As people get more used to them, it will probably go down, but to educate people on the policies, make them more clear, we think is really a key to keeping the appeals backlog lower.

Mr. HORSFORD. Okay. I know my time is up for this round, so I'll come back to additional questions.

Mr. LANKFORD. I recognize the chairman of the full committee, Chairman Issa.

Mr. ISSA. Thank you, Mr. Chairman, and thank you for holding this important hearing.

The gentleman from Nevada and I don't always agree, but every once in a while there's a nuance of agreement from this extreme to that extreme of the dais, and this is one where I think the entire committee is frustrated. And Chairman Lankford's work on this, in addition to ENC, I think, really shows how bad things are. And let me just give you two questions and then we'll go into comments.

Dr. Agrawal, let me just ask you, and for the IG, Mr. Ritchie, New York City—New York State owes us $15 billion in overpayments. They flat-billed more than the CMS maximum for Medicaid for—and we held hearings on that more than a year ago.

What have you done to get $15 billion back while in fact you're sending out hordes of people to harass doctors with a less than stellar success rate of success and accuracy in the audits? What have you done to get back from a State that knowingly billed far greater than the rate, and it's $15 billion? It's 10 years worth of your recovery. Any answers?

Dr. AGRAWAL. Sir, that is an area that we are looking at now at the——

Mr. ISSA. You're looking at it. $15 billion, and you're looking at it.

Dr. AGRAWAL. At the request of the committee, we have—we are currently taking on an evaluation of the—of New York State. We're waiting to get the findings and then release the results, after which time I think we can have a conversation about how to proceed.

Mr. ISSA. The newspapers make it abundantly aware the numbers speak for itself, because they're hard numbers of what was sent out versus the maximum allowed in law, and you're looking at it more than a year later.

Dr. AGRAWAL. Sir, I think these evaluations do take time. They are rigorous, they're designed to be rigorous. We——

Mr. ISSA. Oh, they do. Do you know how many doctors have to had stop their practices and answer nothing but questions, because you take their money and then they try to get it back? Isn't that correct?

Dr. AGRAWAL. I wouldn't characterize it as stopping their practices during——

Mr. ISSA. No. I'm telling you that doctors, in some cases, have to stop their practices, because the audits for small practitioners

are incredible detail, and they don't get their money back until they prove their innocence through the process.

So let me go through this again. You have the right to stop payments in your State based on a good faith belief they got over $15 billion, and then they can spend legions of time trying to argue why they should get to keep far more than they were supposed to receive, couldn't you?

Dr. AGRAWAL. I'd have to look into whether or not we have that authority, sir.

Mr. ISSA. Well, why don't you look into it, Doctor. And while you're looking into it, pursuant to congressional action under the Small Business Jobs Act, you owe ENC and subsequently, we get a copy of it, you owe a report, a second year report on predictive modeling, don't you?

Dr. AGRAWAL. Yes, we do.

Mr. ISSA. And you've owed it since October?

Dr. AGRAWAL. I believe the—I believe the report has actually been due since earlier this year, but I take your point.

Mr. ISSA. No, you don't take my point. We just did away with a whole bunch of reports by congressional action, ran it through the House. It's over—I think the Senate may have already acted on it, because we do ask for reports we don't always need, but we didn't just ask for this report, we ordered the executive branch to deliver it. It is extremely important, because the kinds of things that the gentleman from Nevada were talking about, auditors going out half you know what, being wrong, and on appeal often being dramatically overturned, even to zero dollars in some cases after physicians and clinics go through a great process, that—much of that would go away if your predictive modeling went and looked for the fraud where it was most acceptable—most likely to occur.

Mr. ISSA. Mr. Ritchie, are you concerned that Chase Manhattan can see your credit card perhaps being misused and calls you, but the organization that you are auditing has no such capability?

Mr. RITCHIE. That is definitely a concern. I mean, we do think that the fraud prevention system has taken steps and shows promise.

I know—I am tying to the other question with our RAC work—one of the things that CMS does when they look at the RAC audits is they identify vulnerabilities, if there is cumulative issues over 500,000, and they need to address those vulnerabilities and then assess them.

So one of our recommendations was to fully do that because we had found, you know, once they identify and recover repayments, you need to set up the safeguards to prevent them from occurring in the future so you don't have this problem.

Mr. ISSA. And has the IG looked into the excess payments requested by and given to the State of New York that this committee earlier had as to whether or not any criminal charges could be brought?

Mr. RITCHIE. I am not aware of that. I don't believe we have looked at criminal charges. I do know that we have——

Mr. ISSA. But they knowingly overcharged more than the maximum and then they cross-funded that payment to other services not covered by CMS in many cases.

So the question is: Is it even worth taking a look to see whether or not the threat of criminal just might get New York to return $15 billion in excess payments, ten times what your audits that we are talking about here today, in part, are revealing?

Mr. RITCHIE. Personally, yes. I think it is worth it. I am not the enforcement person, but my office in Audit—we have done a whole series of audits in New York that we have shared with the committee. And I can go back to the office and talk to our investigators about this and our counsel and look into it.

Mr. ISSA. Okay. Well, Mr. Chairman, I appreciate your giving me a little extra time.

I will say that I am deeply concerned that reports required by Congress that ultimately are necessary in order to improve the system are clearly done, but are being held back so they can be sort of looked at again and again.

This is the politicking of releases. And I would only suggest to the chairman that we have the authority to compel the work documents if we need to, if that report doesn't come in a timely fashion from here on.

And I yield back.

Mr. LANKFORD. Dr. Agrawal, just before I yield, this was a pending question from the chairman: When will that report come? We know it is months late. When?

Mr. AGRAWAL. So, as you know, the Small Business Jobs Act requires us to not only produce a report, but to have the results——

Mr. LANKFORD. When?

Mr. AGRAWAL. —certified by OIG.

We are in the process of working with the OIG to achieve that certification. That is taking some time. I hope to release it as soon as we can.

Mr. LANKFORD. That doesn't answer a "when," does it?

Mr. AGRAWAL. I cannot give you a specific timeframe right now.

Mr. LANKFORD. Can you give me—is it a week or is it a decade?

Mr. AGRAWAL. It is less than a decade, sir.

Mr. LANKFORD. Great.

Mr. AGRAWAL. What I can tell——

Mr. LANKFORD. How much less?

Mr. AGRAWAL. What I think is——

Mr. LANKFORD. This is a report all of us want. It matters to all of us because it deals with what we are all dealing with with providers. Trying to shift us to where we all want to go.

When? Is it a month? Is it 2 months? This is a simple question from the chairman. When?

Mr. AGRAWAL. I cannot give you a specific date. However, I think what is important for the committee and for, you know, the American people and public transparency is that we not only release a report, but that we release it with certification from the IG so that people can trust the numbers and base future decisions upon a certified report. I think the importance of that is clear. So we are working to achieving that.

Mr. ISSA. Mr. Chairman, only because the doctor did say "public transparency," public transparency would be releasing all of the work documents that show the reason for the delay, the discussion, the political correspondence, the loop to the White House that oc-

curs on each of these reports. I rather doubt we will get that transparency.

Mr. LANKFORD. We will want to have that.

Ms. SPEIER. Mr. Chairman, would you yield?

Mr. LANKFORD. I would yield.

Ms. SPEIER. Doctor, you know, it is a pretty simple question. If you can't give us a precise date, is it 3 months? Is it 6 months? And what is holding it up?

Mr. AGRAWAL. As I mentioned, you know, again, it is the—we are working closely with the Office of Inspector General, as required in the law, to try to achieve certification for this report.

I think the importance of that is very clear so that people can not only get a report, but can trust the numbers that are in the report.

Ms. SPEIER. You know, we are not stupid up here. We understand when people are trying not to answer a question.

So if you would be kind enough to answer the question. Is it 3 months away? Is it 6 months away? And what is holding it up?

Mr. AGRAWAL. I cannot give you a specific date. The reason I cannot is because it is a process that is being worked in collaboration between CMS and the Office of Inspector General.

Ms. SPEIER. Well, you can give us a precise date. You need to maybe ask someone else, but we expect to know. We have the right to know. If there is a problem holding it up, we have a right to know what is holding it up.

Mr. AGRAWAL. It isn't an issue of holding up the report, Congresswoman.

Ms. SPEIER. You have a draft report that is complete.

Is it just being agreed to by various parties that then makes it available to be released?

Mr. AGRAWAL. Again, I think our——

Ms. SPEIER. Just answer that question.

Mr. AGRAWAL. Our objective is——

Ms. SPEIER. Answer the question.

Mr. AGRAWAL. We are working with——

Ms. SPEIER. Is the draft complete?

Mr. AGRAWAL. There is a draft report that is—that utilizes the methodology to arrive at savings numbers that the Office of Inspector General is reviewing or is in the process of reviewing.

We hope to be able to release that report in the next month or two. I cannot be more specific than that because it does depend——

Ms. SPEIER. That is helpful. That is a lot better than earlier.

Mr. LANKFORD. Ms. Duckworth.

Ms. DUCKWORTH. Thank you, Mr. Chairman.

I would like to follow up a little bit on what the chairman of the full committee, Mr. Issa, was talking about, these RAC audits.

I agree that combatting Medicare waste and fraud is a critical goal. In fact, there are studies that show that as much as $50 billion are wasted each year due to fraud, waste and abuse in both Medicare and Medicaid. We need to go after that.

But it has also become clear to me that the well-intentioned efforts of CMS to accomplish that goal are not working and are badly in need of reform.

I want to talk specifically about how these audits—these RAC audits affect the orthotic and prosthetic industry and the patients that they serve.

I have personally heard from providers all over the country, many of whom are small businesses, how they are being targeted by overzealous and misdirected audits that are threatening to put them out of business.

They are having to wait years and carry hundreds of thousands of dollars on the books that they are not getting paid for, and these businesses simply cannot survive this.

Taken collectively, the stain on the industry undermines access to critical services for patients who have suffered from limb loss or limb impairment.

Oftentimes, these businesses are the only providers of prosthetics and orthotics in their local area, which now means that the patients cannot get access and must go without the limbs and medical equipment they need for their lives.

The volume of audits has led to a huge backlog in appeals for providers who feel that they have been wrongly denied payment for very legitimate services.

I am particularly concerned that CMS has chosen to deal with this backlog by suspending for 2 years the ability of providers to appeal decisions at the administrative law judge level.

With ALJs siding fully with providers in over half of our decisions and in a context of increasingly aggressive CMS audits, it is simply unacceptable to deal with the problem by denying the providers due process.

They are continuing the audits. You are taking these people's money by not paying them and saying, "Now you have no right of appeal. You are going to have to wait for over 2 years."

That is not the way businesses work. And you are going to drive these hard-working Americans, these small business owners, out of business, and you are going to leave all of their patients out there without the limbs and the equipment that they need to—in order to live their lives.

At the public hearing on this issue, the Chief Administrative Law Judge Griswold gave an explanation of how the Office of Medicare Hearings and Appeals of—their position, but really offered no short-term remedies that would restore the right of a timely due process to providers.

If you are going to suspend the hearing by 2 years, then suspend the RAC audits for 2 years. Give them their money back and collect it 2 years later. It seems blatantly unfair and un-American to take these folks' money and not give them the right to due process.

Mr. Agrawal, does CMS have any plans to restore fairness to the system for our providers?

Mr. AGRAWAL. So just to clarify at the outset, the third level of appeals or the administrative law judge level is outside of the jurisdiction and oversight of CMS. It is overseen by OMHA. What we have direct oversight over is the first two levels of appeal.

Ms. DUCKWORTH. Okay.

Mr. AGRAWAL. Everybody is afforded—you know, any over-determination, whether by a MAC, RAC or other contractor, providers are afforded the opportunity to use that appeals process as part of

their oversight of us to make sure that the audits are being conducted appropriately and the right determinations are being arrived at.

Ms. DUCKWORTH. What is the backlog at the first two levels? How long are they waiting for—to get into the appeal process and getting a result?

Mr. AGRAWAL. At the first two levels, the second of which is an independent level of appeal or oversight, the OIG has actually published a report that shows that there is no substantial backlog at the first two levels of appeal. The backlog issue really arrives later. And, on average, we are within the timeframes that are required of us.

I would say, you know, in addition, with respect to the orthotics and prosthetics issue that you brought up earlier, this is clearly an important area. And if there are, you know, issues of access to care with respect to specific beneficiaries or companies, I am happy to work with you on that. That is a priority for us. So I am happy to work with you on it.

Ms. DUCKWORTH. Excellent. I will have the orthotics and prosthetics industry come in and sit down and talk with you.

Let me ask this: So what you are telling me is the third level of appeals is holding everything up and they have suspended for 2 years the right to due process and, even though this is being caused by the RAC audits that CMS is continuing to conduct, it is not your fault, it is someone else's fault, but you are still going to shove more people into the system who now have no access to this?

I mean, it is kind of convenient, don't you think, that you are pushing people into the system with these aggressive RAC audits, but, on the other hand, you are saying, "It is not our fault that they can't get through the third level?" What are you doing to work with the administrative law judges to fix the delay in the appeal process?

Mr. AGRAWAL. Sure. So we have taken a number of approaches to ensure that, number one, the audits are being conducted appropriately and then wherever we can to help address appeals issues. We are actively working with OMHA on their backlog and trying to arrive at solutions in conjunction with them.

I think on the front end, where we have, again, more direct oversight and authority, we have implemented certain strategies to ensure that the audits are being conducted correctly, that they are being achieved with high accuracy.

As just one example in the RAC program, we do have a validation contractor that looks behind the RACs to make sure the RACs are following CMS requirements, CMS payment rules, CMS guidelines. And all of the RACs have achieved a well above 98 percent accuracy rate of their findings.

I think that goes a long way to ensuring that the RAC activities are, in fact, being monitored. And while providers will always have the opportunity and should have the opportunity to appeal, we want to make sure that the initial determination is accurate.

Ms. DUCKWORTH. I don't think it is accurate when over 50 percent are being overturned on appeal. I think that that is a pretty high failure rate of your RAC audits.

I am out of time, Mr. Chairman.

Mr. LANKFORD. I would like to ask unanimous consent. There is a statement that has been sent to us by the American Orthotic and Prosthetic Association. I would like to ask unanimous consent that this be entered into the record. Without objection.

Mr. LANKFORD. Mr. Meadows.

Mr. MEADOWS. I want to follow up on that because you are acting like you have nothing to do with this backlog, and I think that that is an unfair characterization.

Do you not agree? You have nothing to do with the backlog?

Mr. AGRAWAL. I think, you know, clearly providers would not have a lot to appeal if we didn't enforce our rules and deny certain payments from being made.

Mr. MEADOWS. Okay. Well, let us look at this, the Inspector General's report. And they said that the overturn rate at the appellate level is anywhere between 5-—depending on how you read it, between 56 to 76 percent, according to the OIG.

And so those don't get to that adjudication level without you doing something. Isn't that correct?

Mr. AGRAWAL. We, you know, clearly do—I think we have a number of steps that——

Mr. MEADOWS. You have to review them first before they get here.

Mr. AGRAWAL. They do have to be reviewed by a contractor first.

Mr. MEADOWS. And then they get overturned between 56 to 76 percent of the time, according to this OIG report in 2010.

Do you disagree with that?

Mr. AGRAWAL. No, sir. Not only do we——

Mr. MEADOWS. So you do have part of the reason why we have a backlog because it is on the front end. You are just denying claims and denying claims.

I have talked to physicians. I have talked to hospitals. I have talked to healthcare providers. And you know what?

They say the first fair hearing they get is at the administrative law side of things and that what happens is you guys are just denying them and you are saying, "It is tough. You have to pay it and wait for your turn in the queue to get the hearing."

Do you think that is fair?

Mr. AGRAWAL. I don't think that is a correct characterization.

Mr. MEADOWS. Okay. All right. Well, let me ask you another question. This comes from the hhs.gov Web site. And you all changed that within the last 30 days. It has been changed.

And what this says is that the average processing time for appeals are decided in 356 days. Would you agree with that for fiscal year 2014?

Mr. AGRAWAL. Again, sir, if you are talking about the third level of appeal or the ALJ level, I couldn't comment on their data.

Mr. MEADOWS. Well, this is on your site. Fiscal year 2014, the average appeals time is 356 days.

Would you agree with that for fiscal year 2014?

Mr. AGRAWAL. I think, if that is what the data shows, then that is clearly what it shows. I think our number——

Mr. MEADOWS. So how do we know that? Fiscal year 2014 hasn't even ended yet. It doesn't end until September 30. So how would you know this?

Mr. AGRAWAL. Sir, I am not exactly sure what data you are looking at or how it reflects——

Mr. MEADOWS. It is on your site. I will be glad—we can give you a copy of it. Somebody in your office knows because you have changed it within the 30 days.

Because what you were saying is that they were not being assigned for 28—and I will give you—28 months that they weren't being assigned and that has been changed.

Who changed it?

Mr. AGRAWAL. I think all of the issues that you are describing, if, hopefully, this is accurate, is that they are really the third level of appeal or ALJ level sort of issues.

What I stated earlier is that we have oversight of the first two level of appeals and we are abiding by the time lines required in those appeals.

Mr. MEADOWS. Let me tell you. Moms and dads back home, they could care less about the internal divisions. They see it as all part of CMS. They see it as one in the same. They see it as the government. And so here we are for the budget request that we have got that says the backlog is going to reach 1 million.

At what point does it become a crisis? At what point? When does it become a crisis? When do you start putting companies out of business? Because you already are. When does it become a crisis that you are willing to do something about? This is your document. 1 million backlog by the end of this year. So is that a crisis?

Mr. AGRAWAL. Well, sir, if there are individual companies that are being put out of business by these audits, we do have flexibility in how we achieve——

Mr. MEADOWS. But you don't. I have already called on behalf of some of my constituents, you know. And that would be a great response, but it is not true.

Because you know what? I have dealt with Jonathan Blum. I have called to make sure that Kathleen Sebelius knew about it. I have called the White House. And you know what? You say, "Too bad."

So what do I tell the moms and dads who are going to lose their job because they do not get a fair hearing? What do we tell them?

Mr. AGRAWAL. Well, sir, we are able to do what we are authorized to do. So whether it is an alternative payment arrangement or something else working with a provider, we can do what we have——

Mr. MEADOWS. All right. So you have got 5 years for an alternative payment arrangement. I know this stuff. I have been studying it for the last 6 months. 5 years.

So if the backlog is 10 years, what do they do? They just pay it?

Because right now, at 1 million people—at 1 million appeals, your rate—the best rate that we have had from the adjudicators is 79,000 a year. And even with your budget increase, that would still be a 10-year delay. That is a taking, in my book.

Would you wait for 10 years for your salary? Yes or no.

Mr. AGRAWAL. Sir, we do whatever we are authorized to do in terms of working with providers to try to make the system less burdensome for them.

We can stretch out payments. We can change things in individual cases. But, again, we cannot overstep the authority that has been granted to us by Congress.

Mr. MEADOWS. All right. But something changed. Something changed. Because you know what? The audits went from 1,500 a week to 15,000 a week. So what did you change?

Because, I mean, it is in your documents. I will be glad to give you that, too. Actually, it is worse than that. They said it went from 1,200 and change a week to 15,000 appeals a week. What did you change?

Mr. AGRAWAL. So, again, I think it is important to level-set on this. It is our obligation to audit. We have improper payments that you have heard about from other witnesses, that you have heard about from the rest of the committee.

It is our obligation to go after those improper payments to try to reduce the rate and make recoveries where possible or, you know, where they should be made. That is an obligation created in law.

And to also level-set, sir, on the amount of auditing that we do, we audit far less than 1 percent of all claims we receive.

In fact, all of the overpayment determinations made by RACs in the latest available data to the public account for less than 1 day of claims that come to the Medicare program.

Mr. MEADOWS. All right. My time has expired.

I would like one answer to this: The law says that they need a decision in 90 days. Is that law being violated? And who makes the choice on what laws we enforce and what laws we ignore? The law says 90 days.

Mr. AGRAWAL. I cannot comment on the processes that are outside of the jurisdiction of CMS.

Mr. MEADOWS. This is in your jurisdiction. I will be glad to give you a copy.

Mr. AGRAWAL. That is at OMHA.

Mr. MEADOWS. No. This actually talks about qualified independent contractors, which is under yours, and then the ALJ is after that—90 days after that.

Mr. AGRAWAL. Great.

So as far as the second level of appeal at the qualified independent contractor level, there is recent reporting from the OIG that shows that we are remaining on track as far as the expectations of how long it takes to, you know, go through that appeals process.

Mr. MEADOWS. Jonathan Blum said you changed something in 2012. What did you change?

Mr. AGRAWAL. Sir, I was not a part of that conversation. If you can——

Mr. MEADOWS. Do you know of any changes that happened in 20—I am out of time.

I yield back. I apologize, Mr. Chairman.

Mr. LANKFORD. We will come back around in a second round.

I would like unanimous consent to have Ranking Member Speier's opening statement be entered into the record.

Mr. LANKFORD. Without objection, Ms. Speier, you are recognized.

Ms. SPEIER. Mr. Chairman, thank you. And I apologize for my late arrival. We had a memorial service at Arlington Cemetery for servicewomen and I felt compelled to be there. So I apologize for not being here for your opening statements.

Let me say at the outset I have had local hospitals that have gotten embroiled in the RAC situation. I have a hospital that is teetering on bankruptcy right now, and the RAC experience has exacerbated it.

But I also think it is really important for those of us who sit on this committee to recognize that we have an obligation beyond just beating up on those who come before us like this to recognize that, if we want to fix the backlog, we have got to pay for it.

There is a backlog because, in 2007, RAC claims amounted to 20,000. Today that number is 192,000 a year. That is 10 times what it was in 2007, and we have not added one single person to respond to those claims.

So if we want to deal with this backlog, if we want to erase it, we have got to recognize that you cannot expect people to do 10 times the work with the same number of work-hours.

Now, let me start with Mr. Ritchie, if I could.

You have had a pretty remarkable run in terms of the efforts by the Healthcare Fraud and Abuse Program which resulted in $4.3 billion in recoveries to the Treasury in 2013. That represents an 8-to-1 return.

Is that the highest level of recovery to date, Mr. Ritchie?

Mr. RITCHIE. Yes. That is.

Ms. SPEIER. And how is that achieved?

Mr. RITCHIE. We partner with our other partners in enforcement and the HCFAC Program to fight fraud, waste and abuse through investigations, through audits, through the evaluations that we have done. The recoveries that were reported in fiscal 2013 were record recoveries.

Ms. SPEIER. Now, I think in your testimony you reference that sequestration will result in a 20 percent reduction in OIG's Medicare and Medicaid oversight capabilities. Is that correct?

Mr. RITCHIE. Unfortunately, yes.

Ms. SPEIER. So what does that mean in terms of what you are going to do and what we are going to see in terms of waste, fraud and abuse being properly handled?

Mr. RITCHIE. For our office, it is—I mean, it is not good. It means less investigations, less audits, less evaluations.

I mean, I am not the budget expert, but I certainly live this every day. I work in our audit office and I am acting in charge of our evaluation office.

At this point, between 2012 and 2014, Medicare and Medicaid outlays went up 20 percent, and during that same time, my office has had to reduce our focus on Medicare and Medicaid by 20 percent.

It is really challenging, given we have a $50-billion improper payment, a 10 percent error rate, that we are dealing with this, that it means less auditors, investigators, evaluators on the ground to handle this.

I have been working in IG for 27 years and I can just tell you personally, I mean, I have never felt quite as challenged looking

ahead to see with the growing programs and growing responsibility how we go about doing this because——

Ms. SPEIER. So should we just roll out a red carpet for the fraudsters of this country?

Mr. RITCHIE. I would certainly hope not.

I mean, in our office, we try to do a risk assessment to pick the best topics. You know, we certainly—we make our budget request.

And for us personally, I mean, the best thing that could happen would be to fully fund our budget request to try to get us back on target. It has definitely decreased.

We have gone down by 200 FTEs—full-time employees—over that time. You know, we have had to stop evaluations and audits. We have had to stop following up on investigation leads.

Ms. SPEIER. So is it safe to say that, because of the reduction, there are investigations that haven't moved forward that probably would have resulted in savings to the taxpayers in this country?

Mr. RITCHIE. Yeah. Absolutely. I mean, investigations and audits, both, that we have to make tough choices every day for what we start in and what we can't start.

I mean, it is been a very difficult time in sort of looking at this. I think you are making tough choices. With things that look very good, you do a risk assessment and feel like there is so much to look at, but you know you only have so many resources and those resources are declining.

I mean, we have had a hiring freeze for 2 years and people have left through buyouts. So we have just been consistently reducing.

Ms. SPEIER. So give us an example of the kind of case that you had to let drop by the wayside. I mean, do you drop cases that are just so big that it would take so many resources? So are the big fraudsters getting away with it more than the little fraudsters?

Mr. RITCHIE. Well, I am not in our Audit and Evaluation Offices. So I am not there. I do know that our Investigation Office told me that they have closed 2,200 investigative complaints since 2012.

I think it is a mix. I mean, we try to do the best risk assessment we can and put resources on the biggest cases, but certainly we can't afford to do all those.

I know our StrikeForce activities have been a big success. In our StrikeForce cities, we have had a reduction in resources. So it is been across the board in every aspect of the IG's enforcement.

Ms. SPEIER. All right. My time has expired. I will follow up with the second round.

Mr. LANKFORD. Mr. Chaffetz.

Mr. CHAFFETZ. I thank the chairman.

And, Ms. King, I appreciate this GAO report that you put out. I want to go to the first complete page. This is the second paragraph, the latter half of it. I will read it to catch everybody up: For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses, meet certain Medicare standards, and are at legitimate locations. CMS also recently contracted for fingerprint-based criminal history checks of providers and suppliers is has identified as high-risk. However, CMS has not implemented other screening actions authorized by the Affordable Care Act that could further strengthen provider enrollment.

Can you help enlighten me where you think they have not implemented other actions to strengthen the process?

Ms. KING. Yes. I think there are a few things that we point out.

One is in relation to surety bonds, establishing a regulation regarding surety bonds for certain types of providers.

One is in not publishing a regulation that has to do with disclosure of past actions that have been taken against providers, such as payment suspensions.

Mr. CHAFFETZ. So, Doctor, why not do that?

Mr. AGRAWAL. I think these are great ideas. And we have really appreciated—the Agency has appreciated working with the GAO on ferreting out where our vulnerabilities and weaknesses are and trying to do something about them.

There is, you know, nothing conceptually wrong with these recommendations. We continue to have the conversations. We have to prioritize changes——

Mr. CHAFFETZ. Yeah. But I am just wondering why you haven't done it. I mean, we are trying to get rid of the waste, fraud and abuse. Right? And it is authorized by the law. Why haven't you done that?

Mr. AGRAWAL. Absolutely. It isn't, I think, you know, a disagreement over the objectives. We have done a lot in the last couple of years to really, you know, beef up our approach to provider enrollment and screening.

Some of the stuff, like fingerprinting, is just coming online now. So, you know, there are just bandwidth limitations in terms of what we can get to and how quickly, based on resources, based on budget.

Mr. CHAFFETZ. Is there a prioritized list or summary that you could share with the committee so we can understand what you are prioritizing, what you are doing and what you are not doing?

Mr. AGRAWAL. Well, I think you are clearly seeing some of the priorities already occurring.

Mr. CHAFFETZ. I know.

But where do I find that? Where do I—is that something you can provide the committee?

Mr. AGRAWAL. I don't know that we have a list. I am happy to have further conversations with the office——

Mr. CHAFFETZ. Can you create a list?

Mr. AGRAWAL. Um——

Mr. CHAFFETZ. We are trying to get some exposure, some transparency, which you say you are in favor of, of what you are doing or not doing. The GAO right at the front is saying you are not doing all that you could do.

I am sure there—you have got to make some choices. I want to understand what you have prioritized and what you are doing and not doing.

Is that fair, to put that on a piece of paper and share that with the Congress?

Mr. AGRAWAL. Well, I think perhaps it would be useful to get your insights and, you know, we can continue——

Mr. CHAFFETZ. No. No. No. Wait. Wait.

Mr. AGRAWAL. —to have conversations with GAO on, you know——

Mr. CHAFFETZ. If you want me to run your agency, I will run it for you.

But GAO is making recommendations authorized by the law to do these things. I just want to see what you are doing and not doing.

I am not looking for a 700-page report. I am looking for a couple-page summary to understand what you are implementing and what you are not.

Mr. AGRAWAL. Sure.

Mr. CHAFFETZ. You have got to have some sort of document.

Mr. AGRAWAL. We will work on——

Mr. CHAFFETZ. I didn't expect to spend 5 minutes asking you if you had a prioritized list of what you are working on.

Is that something you can or cannot provide to Congress?

Mr. AGRAWAL. Sure. We will work with your office and we will provide it.

Mr. CHAFFETZ. When is a reasonable time to get that document? You come up with a date.

Mr. AGRAWAL. Can you give me a few weeks to do it?

Mr. CHAFFETZ. Sure.

Mr. AGRAWAL. Great.

Mr. CHAFFETZ. Pick a date.

Mr. AGRAWAL. How about a month? We will get it back to your office within a month.

Mr. CHAFFETZ. The end of June. How's that?

Mr. AGRAWAL. Perfect.

Mr. CHAFFETZ. Okay. Thank you very much.

One of the things that I have been working on that I am worried about are these providers.

Are we engaging in allowing people that have serious delinquent tax debt to be engaged in this process?

This is a big government-wide problem I see, is that we have contractors out there who have serious delinquent tax debt. We, yet, hand them new additional contracts and allow them to continue to be involved and engaged.

I would provide—and I don't expect you right off the top of your head to understand the answer to that question, but that is something else that I personally and I think the committee would benefit from understanding.

What are the policies that you have there? What are—it should be a key indicator to me that, if you are unable to pay your Federal taxes, why do we continue to contract and give you more and more business?

The President has been supportive of this when he was Senator Obama. I think this is a very bipartisan thing. This committee has dealt with a bill very specific to that.

If you could also provide me information about what you do with that. And the answer may be, "We don't do anything with that." I would just like to know the answer to that question.

Can we also shoot for the end of June that you give me that information? Is that fair?

Mr. AGRAWAL. Yeah. I think that is fair.

But I think, just to comment on that a little bit, we have—you know, there is all kinds of information that we could conceivably collect from providers.

I think the question often, you know, that we have is: What information can we collect that is actionable for us? So there are some clear bright lines in the program.

If you don't have the right license to practice medicine in the State in which you want to enroll, then you don't get to enroll in that State. There are certain other types of disqualifiers, like certain felony convictions.

So I think, conceptually, it makes a lot of sense to include as much kind of risk assessment data and analysis as one could to look at providers.

But, again, I think we have to—there is really just a subset of those potential risks that pushes us over the line and allow us to take action. If a provider ends up on, you know, the exclusion list or the do-not-pay list, that is helpful.

Mr. CHAFFETZ. Well, and I am also worried about the contractors that you are engaging that are supposed to help ride herd on this, that are supposed to help you engage these people. Those are some of the specifics that I would like to see as well.

It is not just—I am not talking about the providers as much as I am the contractors that you are contracting with in order to make these things happen.

Thank you, chairman. Yield back.

Mr. LANKFORD. Thank you.

I am going to open this up for the second round for questioning. During this questioning time, there is full interaction on the dais. You can jump in at any time. There is no clock running this time period if you have interaction.

Also, for our witnesses, if you have specific things that you want to get into the conversation, you are free to be able to initiate the topics in the conversations as well to make sure that you are clear.

Our goal of this conversation is to make sure that we bring all the issues out, find the areas that need to be resolved and what is the timeline for resolution on those things. So you are free to be able to bring the issues up as well to make sure we have clarity on this.

I want to reaffirm again—let me take first crack at a few things here.

I want to reaffirm again that this panel, myself included, is committed to how do we deal with fraud. There is $50 billion in unaccounted-for money, possible overpayments in fraud.

We affirm that we are pursuing that fraud. That is the taxpayer dollar and it is essential both for the solvency of the program long term and for the taxpayers themselves. So continue to do that.

I think the frustration is the prepayment side of this. We all know that is the direction it should go so we are not having to chase. That is why we want to know the report.

We want to know what is happening at this point, how we get ahead of this in the days ahead, so we are not having to constantly go back to good providers and to say, "We are going to hold some of your dollars."

Many of these providers may have a 2 or 3 or 4 percent profit rate and, for them to have a portion of their cases pulled and not paid for for an indefinite period of time as they go through the appeals process is untenable to them.

So I want you to hear from me and from us. We are not opposed to going after fraud. We are opposed to the methods that is—currently and as it is being executed.

There have been changes in the RAC audit process as CMS has learned its way through this. We are proposing additional changes in this to say what can we do to help expedite this process and to make sure, when it is right and it is overturned in appeals, they get their money faster and they have fewer people engaged.

So let me run through a couple of these things again.

We have gone through the revalidation process. Is that complete at this point for providers nationwide where we revalidated the providers?

I know we have done fingerprinting, we have done background, they have had to reenroll. Is that complete at this point? What stage is that in?

Mr. AGRAWAL. So the revalidation process that was initiated after the ACA puts us on a 5-year cycle. I believe the latest number is we are—we have revalidated over 770,000 providers at this point. That puts us on track to be complete in time for the first cycle.

Mr. LANKFORD. So 2 more years still left of that is what you are saying or——

Mr. AGRAWAL. I think that is about right, yes, if I am remembering correctly.

Mr. LANKFORD. Okay. And then the prepayment pursuit of fraud, we have a report that is due to us. Obviously, we have already discussed that is coming in the next couple of months to give us the details and the progress on that.

Then we move into the post-payment. Do you want to make any comments on the prepayment side?

Mr. AGRAWAL. Well, I think just that, clearly, the Affordable Care Act did provide us a lot of authorities to make changes on the prepayment front, such as, you know, payment suspensions, which we are now able to leverage against the worst actors.

I think the only point that I would make, Congressman, is to differentiate what we do when we are going after potential fraudsters, sort of criminals, the worst actors.

From those providers, the vast majority that are perhaps producing waste or producing inefficiency in Medicare, not quite following our rules, but have the intention to follow our rules, are trying to actually do their best.

I would just ask us to sort of keep this framework in mind because I think it sort of determines for us what tools we utilize so that they are not overly pejorative.

I think payment suspension, for example, is a great tool for the worst actors and, though it is prepayment, it is not a great tool for legitimate actors because it essentially suspends all the payments that they would be getting.

Mr. LANKFORD. Right. Well, you are dealing with the same thing. It is the hammer that is down in the area.

Even for the high-risk areas where there is a moratorium, some of those areas may have a deficiency of a number of good companies that are actually providing. And as we continue to have more people entering into Medicare, there is a need for providers.

And so even, when a moratorium occurs on that, that is a pretty incredible hammer for that region to say there is lots of small businesses that won't start up during that time period that could be legitimate providers.

Mr. AGRAWAL. It is—I agree with you, sir. It is a notable piece of authority that we implemented with a lot of care and over time. So it took us years to go from having the authority in the ACA to actually implementing it for the first time.

I would say the areas that we tried to address, both the geographies and then home health services as well as ambulance services, are areas that we knew there was a lot of market saturation. There was very little concern, though we have been looking at it continuously, about access-to-care issues.

You know, home health and ambulance services in Texas and South Florida are areas of a lot of agreement with the Office of Inspector General, the Department of Justice within CMS, with State Medicaid agencies, that there is just a lot of market saturation, sort of three to five times the number of providers than on average areas.

So while access to care is clearly something we care about and we are looking at in realtime to make sure the moratorium does not have negative impact on access, we are currently not seeing it in those areas.

Mr. LANKFORD. Okay. Let me come back to one last thing. I want to open this, but I don't want to take all the time on it.

The four appeals that are total, I would like to get just a timeline for everyone the length of time. You have said they are on schedule.

So let's talk about Appeal Number 1. If someone has a problem with the RAC audit, Appeal Number 1 is to who and how long does that take?

Mr. AGRAWAL. Sure. So I believe the first level of appeals providers have 120 days to file the appeal and then there is a 60-day time limit for the decision to be achieved on the appeal.

Mr. LANKFORD. Okay. So they filed it right away, let's say. Let's talk about your end of it. Their responsibility is their responsibility.

So you have 60 days to respond. Correct?

Mr. AGRAWAL. Correct.

Mr. LANKFORD. Who is that that is responding to them? They are appealing to who?

Mr. AGRAWAL. I believe in almost all cases it is the MAC administrative contractor that would handle the first level.

Mr. LANKFORD. Okay. So you have got—the RAC folks make a decision and then the MAC folks then are making the response in the appeal. Is that correct?

Mr. AGRAWAL. Correct.

Mr. LANKFORD. Okay. So they have 60 days to respond. You are saying that is on time?

Mr. AGRAWAL. Yes.

Mr. LANKFORD. They disagree with that. They come back in the second level.

Who is that? How long does it take?

Mr. AGRAWAL. So the second level goes to the qualified administrative contractor, the QIC. They have, again, 180 days to file the appeal—the provider does—and then we have 60 days to make a decision on the appeal.

Mr. LANKFORD. And you are saying that is on time as well?

Mr. AGRAWAL. So I have average times that are below the 60-day mark. Correct. Sort of 53 and 54 days for most appeals.

Mr. LANKFORD. And do you have the overturn rate on both of those?

Mr. AGRAWAL. It would depend on the specific audit.

So is there a particular audit that you are referring to?

Mr. LANKFORD. Yeah. Either one. The first or the second level.

Mr. AGRAWAL. And RAC audit, sir?

Mr. LANKFORD. RAC audits. Yes, sir.

Mr. AGRAWAL. I would have to look.

Mr. LANKFORD. All right.

Mr. AGRAWAL. So I think—while I am looking, let me just say I think the overall overturn rate for the RAC audits are, you know, between parts A and B, about 6 to 7 percent. That is in the latest data. That is public.

Mr. LANKFORD. But you are not talking through the ALJ process. You are just talking through the first—that is what we are trying to figure out. We are trying to get a cumulative number. We have yet to see a cumulative number.

Mr. AGRAWAL. No. I believe—so I believe that the 6 and 7 percent numbers are—all the way through are ever overturned.

Mr. LANKFORD. Okay. I am trying to figure that out because the latest numbers we have seen on the ALJs are between 56 and 70-some-odd percent of overturned just in that level.

Mr. AGRAWAL. Correct. So—if I could perhaps explain it a bit, so the RACs, you know, make determinations. I think the latest public data is 1.6—roughly 1.6 million claims were found to have contained some kind of overpayment.

Providers then make a decision about whether or not to appeal those overpayment determinations. And, basically, at every level of appeal, as you go from one, two, and three, the number of claims going to the next level comes down and the overturn rate might vary between the levels.

So I am not finding the number right away, but I think at the first two level—oh. That is very helpful. Thank you.

So at the first two levels, we are seeing a 9 percent overturn rate for the RACs in specific.

Mr. LANKFORD. Both of them or each one? 9 percent at the first level and then another——

Mr. AGRAWAL. No. At the first level of appeal, 9 percent for part A.

Mr. LANKFORD. But you don't have part B?

Mr. AGRAWAL. 3 percent.

Mr. LANKFORD. All right. And for the second level of appeal?

Mr. AGRAWAL. At the second level, for part A, it is 14.9 percent.

Mr. LANKFORD. So 15 percent, basically.

And then part B?

Mr. AGRAWAL. .5 percent—no. I am sorry. I am not sure if that is right. You know, I don't have it called out.

I have just the percentage of RAC appeals that actually make it to the second level, but I don't have the overturn rate for part B on the second level. We can get that to you.

Mr. LANKFORD. Okay. That one is unknown.

And then they go to—after that, they have done 60 days in the first one, they have done 60 days in the second one, and then they disagree with that as well, and now we are headed to the ALJs, which, as Mr. Meadows has commented on, now could take 10 years to get to that spot, depending on the perspective you get.

Now, we have heard 28 months, but 28 months is pretty ambitious, based on the number of people that are in the queue and the number that have been typically handled.

I know you have said over and over again that is not your responsibility. We will visit with chief ALJs on this. But that is the next level.

Then the fourth level is what after that? If they disagree with ALJs, then what?

Mr. AGRAWAL. There is another level that they can go to which is, I think, at Federal District Court level. I am sorry. It is the Departmental Appeals Board and then, after that, it is the Federal District Court.

Mr. LANKFORD. So that is a fifth level?

Mr. AGRAWAL. Correct.

Mr. LANKFORD. Okay. Thank you. I wanted to get the context for everyone.

Jump in at any point.

Mr. MEADOWS. I guess my question is: —so let's look at part B, DME only. What is the overturn rate for that, which would include, you know, some of the other stuff?

Well, let me ask—I have got a report here from your office prepared on April 2 of 2014. It says that the overturn rate is about 52 percent. Is that correct? Is this report correct from your office? Would it be about 52 percent for DME overturn rate?

Mr. AGRAWAL. I think it really depends on what document and what level you are looking at. If you look at all DME claims, again, it is—about 7.5 percent of all overpayment determinations end up in an overturn on appeal.

Mr. MEADOWS. We are talking about on the appellate part. This is Office of Medicare Hearings and Appeals, their report.

Mr. AGRAWAL. Okay.

Mr. MEADOWS. So those hearings and appeals.

It says that the overturn rate is—52 percent is either fully favorable or partially favorable. 24.87 was unfavorable. And so, with that, it would indicate that the overturn rate is much higher than what you would indicate on DME.

Mr. AGRAWAL. There is a calculated overturn rate at each level. So what I just communicated about the first two levels just gives you the overturn rate for those levels. There is clearly a third rate.

Mr. MEADOWS. Okay. I may not be real sophisticated. So I am trying to figure out—how does your report say 52 percent here and

what you testified says—where's the difference? Help me understand that.

Mr. AGRAWAL. So, generally, as you go up at the various levels of appeal, providers make a decision at each level about whether or not they are going to appeal to the next level.

What we see are some general trends. So providers do tend to—the number of claims that are appealed at each level does trend to drop and the overpayment—or the overturn rate can increase.

So at the third level of appeal, at the ALJ level, the overturn rate is—I can totally agree with what is on your piece of paper, that it probably does approach 50 percent for DME.

Mr. MEADOWS. All right. So——

Mr. AGRAWAL. But at lower levels of appeal, given that there is more claims that are appealed and fewer are decided in the provider's favor, the overturn rate is much lower.

Mr. MEADOWS. That makes sense.

So out of the 1 million in backlog that your budget request talked about, how many of those would you anticipate, based on this rate, are going to be overturned out of the 1 million backlogged appeals going to ALJ?

Mr. AGRAWAL. I think that is an individual case-to-case determination——

Mr. MEADOWS. It is. But based on historical evidence, how many of those would be overturned?

Mr. AGRAWAL. Sir, I can't——

Mr. MEADOWS. 520,000 of them. I mean, based on these numbers, would that not be correct?

Mr. AGRAWAL. Based on those numbers.

Mr. MEADOWS. Okay. So let me ask you one other question.

The American Hospital Association—they have RAC facts. Per RAC track, which this is all Greek to me, 47 percent of hospital denials are appealed and "almost 70 percent of these appeals are overturned." Is that incorrect?

Mr. AGRAWAL. I can't really speak to their data, sir. What we know—what we—we track the data, of course, very closely internally.

Our numbers would not agree with that. If you look at the first level of appeal for part A, we see about a 5 percent actual appeal rate that makes it to the first level.

Ms. SPEIER. Mr. Ritchie, if I could interject, there is a problem here.

Why is it that, if you have got enough money to go to the third appeal with the ALJ, if you could hold out that long, if you are not a single provider, if you are a big hospital—if you could hold out, if you go to the ALJ, you have got a 60 to 70 percent chance of winning. Why wouldn't everyone just go to that appeal process if they can afford it?

So the question I have is: Why the discrepancy? What do you know about the ALJ system that allows for such huge swings in the determination?

Mr. RITCHIE. Okay. What we looked at, again, was prior to the backlog, but I think it is still relevant. We looked at the ALJs and, at the time, found a 56 percent overturn rate. This was 2010 data.

For the prior level, the qualified independent contractors, there was a 20 percent overturn rate.

The big differences that we saw—again, I have mentioned earlier the unclear Medicare policies we think are a trigger to a lot of this.

At the ALJ level, we found that they tend to interpret them less strictly than at the prior level, at the QIC level, because they are confusing, they are complex policies and they are open to different interpretations.

The other thing, at the QIC level, it is more specialized. They have specific people looking only at part A, specific people looking only at part B, and they have clinicians reviewing that.

Whereas, at the ALJ level, they are dealing with DME, part A, part B, everything that comes their way, and they are relying on documentation and testimony of the treating physician to make their decisions. So the process is different.

We have also seen the case files are different. I mean, it is more of an administrative thing. But the things that they are maintaining and holding in the case files are different from level to level and I think really creates some of the inefficiencies.

For example, the ALJ level is still on paper. So the QIC has everything electronic. They have to print it out and send it to the ALJ. They will also get a paper file of the records maybe from the contractor. So they are trying to sort those two out.

So some of our recommendations are definitely to clarify the Medicare policies, but also to create one system that is electronic that can——

Ms. SPEIER. So if I understand you correctly, at the QIC level, they are very specialized, they know precisely what they are looking for, and they make their determination because they are trained to look for certain things, I guess.

I guess that is part of what you are saying?

Mr. RITCHIE. Correct. We didn't assess and make a judgment of which level is better. They are just very different.

But at the QIC level, we have seen they have clinicians looking at it and they are specific. If an appeal comes in specific to part B, it is going to the QIC. If it comes in to part A, it is going there. Whereas, the ALJ, they have got everything——

Ms. SPEIER. And ALJs aren't clinicians.

Mr. RITCHIE. Right.

Ms. SPEIER. And they are using discretion in terms of interpreting the law.

Mr. RITCHIE. In terms of interpreting the law and then they are relying more on the treating physician's testimony and evidence. Whereas, at the QIC level, they are relying more on their own clinicians to interpret the documentation.

Ms. LUJAN GRISHAM. But—oh, I am sorry.

Ms. SPEIER. Go ahead.

Ms. LUJAN GRISHAM. If Congresswoman Speier will yield, I mean, it speaks to a couple of larger issues.

And I want to get back at, you know, what are the real overturn rates? Are we targeting correctly? And what can we do to improve the system so that we are not harming good providers and which means that we are harming just the beneficiaries going after fraudulent and wasteful behavior.

Medicare is an incredibly complex system and the reality is that, if we don't start dealing up front with the Medicare complexities, we are not—we can chase this all day long and go from one extreme to the other and we are going to find significant flaws in our ability to hold providers accountable and to support providers to do a better job.

And what we haven't done in this conversation is—I am as concerned as anyone else about getting it wrong and overpayments.

I am also very concerned that your part A providers are large providers. Your part B providers, even though we might have, if you will, hot spots with the DME providers, that—they can't afford to go through this process. So, in that regard, your data is skewed for one group.

And I am not trying to vilify one group over another. But hospitals—large hospitals and large hospital groups can afford to wait a decade, potentially. Smaller hospitals, as Congresswoman Speier identified, my colleague from California, cannot.

I want to get back to maybe a couple of things, one—and then yield back.

Can you give us some recommendations—you talked about the predictive modeling. You said we are identifying prescription practices that are clearly problematic.

Is there a way to be targeting those areas? And is there a way to start targeting areas where we have got real issues with access?

Because CMS has a responsibility to assure access. We are only doing one side of this here. We are eliminating potentially access and no response about that.

Mr. RITCHIE. So I am sorry. Could you clarify? Recommendations for what?

Ms. LUJAN GRISHAM. Well, a couple.

And the first is you identified in your testimony that there are areas that you have identified that we could start looking at much more directly in art. So we could do predictive modeling in terms of where folks commonly make mistakes and where we have got potential fraud.

And, two, you identified in that discussion—I don't know that it was tied to the predictive modeling, per se, but you have identified prescription practices that are clearly problematic. You said, I think, that you have got folks who are not prescribers, as an example, prescribing medications for beneficiaries.

Why aren't we focused more in those areas?

And then I wanted either Dr. Agrawal or someone else to talk to me about what you are doing—if you have got hot spots for fraud, what are you doing to shore up mistakes so that we don't lose those providers by providing better education and support to those providers and creating in low access areas, frontier and rural states—what are you doing to ensure you don't lose providers?

Mr. RITCHIE. Okay. Yeah. Thanks for clarifying.

We make those type of recommendations all the time. We have a series of reports that we call our questionable billing reports, several of which I have referred to in the testimony, finding questionable prescribers, questionable pharmacies and questionable home health agencies.

In all of those cases, we take the ones that we have identified that are extreme outliers, based on a statistical test, and give it to our Investigations Office to see if they want to further pursue because these look severe.

After that, we send them to CMS and CMS will share it with their contractors to take appropriate action. And we always recommend that they take the kind of questionable criteria that we have and implement.

I know the fraud prevention system is starting to build some of that in. I think specific to the example that is mentioned in the testimony—and you mentioned on the prescribers—we saw, you know, $5 million in a year prescribed by people without authority to prescribe massage therapists and things.

Just yesterday—I have to look at this because it was late last night that I got it—but CMS actually issued—or published a final rule that requires prescribers of part D drugs to enroll in the Medicare Fee-for-Service Program starting next June, June 1 of 2015, and this is going to allow CMS the plans and the Medicare program integrity contractors to verify that they actually have the authority to prescribe.

Because now they aren't—a massage therapist isn't billing Medicare, but they could write the prescription for drugs that we found that were pretty severe. So that problem will be fixed based on this rule.

So we are working with CMS to get some of the recommendations implemented, but I think it is a combination of doing things like that and implementing edits on a prepay basis to try to stop future improper payments.

Ms. LUJAN GRISHAM. I think what we are interested in—and I am taking too long—but it is to get that information to the committee so we know when so that we can weigh in on how you are balancing these issues.

And if the chairman doesn't mind, can we get something on the access? What are you doing to assure that small providers aren't discriminated even further in this process because of the size of the provider and the capacity of the provider?

And have you thought about treating them differently like we have tiered regulatory environments? What is your thought about making sure that access is protected?

Mr. AGRAWAL. Again—and I appreciate the question. That is an extremely important area for us.

So as far as tiering providers by—we do currently tier providers by size. We actually have medical record request limits specifically for the RAC contractors based on the size of the provider.

I had also mentioned earlier a sort of future solution where we would ratchet down the number of reviews that a particular provider would face if the reviews are generally in their favor, in other words, they are basically following the rules. We are putting that solution into our RAC procurement process right now. So it will be part of the RACs going forward.

I think—you know, in addition to that, we do take—if there are overpayment determinations, we have a process for the provider to work with us and change the payment rate in order to still meet our requirements and still meet the requirements of the law, but

to be able to afford them a longer opportunity so that we don't put providers out of business unnecessarily.

I would also say just on the front end we are undertaking a lot of efforts to better educate providers about our specific payment policies. You know, I think the DME face-to-face—or the home health agency face-to-face requirement is a good example of that where the improper payment rate is very high.

Because of this new requirement, providers need to be brought up to speed, and we are trying to do both specific audits that will look at that issue in order to educate both the home health agencies and the related prescribing providers.

We also have just more general educational materials that providers can take advantage of. We also do try to be very transparent on the front end about what audits we are conducting.

So once a new audit area is approved by CMS, that we put that information on a Web site that providers can look at, both big and small, to shore up their own self-audits, make sure that their compliance programs are working and be prepared for audits in those areas.

We hope that all of this helps to make the process more open——

Ms. LUJAN GRISHAM. And if it doesn't, what do you do to assure access?

Mr. AGRAWAL. Right. So I think—you know, part of it is just we have an open-door policy for providers. So we do want to hear about the shortcomings of these programs if there is an access issue or a burden issue.

Ms. LUJAN GRISHAM. And you don't think that providers by and large are going to be somewhat concerned about that open-door policy, particularly in the context of audits and your efforts for fraud, waste and abuse?

Because when I was the Secretary of Health and Secretary of Aging, I was often—I appreciate that mindset. "We are here to help you." And, by golly, no one believes that.

And so I didn't really find that to be an environment that was very productive, particularly when somebody came to us and, in fact, they were fraudulent and we did our job. And so that certainly precluded that kind of a relationship.

Can you please collect data for us, if you don't already, and provide it to the committee so that I can see—we can see what—the percentage of small providers that are engaged in any level of these appeals versus the large providers?

Mr. AGRAWAL. Yeah. And I think—we can do that. And I think it would be helpful to kind of work out a definition for "small provider" that we could focus on.

Ms. LUJAN GRISHAM. Yeah. And the last thing I would say—and I am trying the patience of this committee and, I am sure, our witnesses.

But I would—again, this committee wants you to ferret out fraud and to stop those bad actors and actually move those to criminal prosecutions and to prevent those folks from ever being able to engage in any of our healthcare systems or any government contracting ever again. We are that serious about fraud.

Now, we also want waste addressed. But I am getting very concerned really about that access issue and that this is completely imbalanced.

And I would like you to consider and mitigate that by telling us what the risks are about changing the withholding of payments for the third level of appeal, taking into consideration, though, a new definition potentially or a refined definition for "small providers" and to entertain that and maybe come back to us in writing about what that would look like.

Thank you, Mr. Chairman.

Mr. MEADOWS. Dr. Agrawal, the passion of which you have heard me today is not meant to be directed at you. It is a passion based on a number of people back in my district that potentially will lose their jobs. And I, for one, nor you, do I believe you want them to lose their jobs because we have a system that is broken.

When the chairman called this hearing, it was really a hearing about making sure that those who steal from seniors—because that is really what this is about, is fraud—those who steal from seniors get caught. But in the process, there are a lot of potentially innocent people that are getting caught up in that dragnet that we have to find a better system to do that.

I would ask for you to submit to this committee, if you would, two legislative changes. If you are saying that your hands are tied, what are the legislative changes that you would support and recommend for this committee to perhaps have the chairman introduce where we can fix it to make sure that we do go after waste, fraud and abuse, but those that are innocent don't have to wait forever to get that innocent verdict and, in the meantime, potentially go out of business?

And I yield back to the chairman. I thank his patience and his foresight in having this particular hearing.

Mr. LANKFORD. Let me ask a couple questions still to follow up on it, and it goes back to what Mr. Meadows was saying as well.

Good actors we want to keep. Our seniors need to know, "In my neighborhood, in my community, in my town, in my county, there is a good actor that is there."

We have all talked to folks, I am sure you are aware as well, on several areas. I had—last weekend I had a gentleman that came to talk to me that wanted to tell me about the last year of his life because he was a durable medical equipment provider. Was. He has now been put out of business.

He was a good guy. He was willing to meet the price that was out there made publicly available in the competitive bidding process, but was not allowed to actually join into that because, as this group knows well, when the competitive bid was put out, if you didn't get the bid, you are out, and not just out, you can't join in even at the new low price. You are just out the business.

He is one of those that came to me and said, "I just want to tell you about the last year of my life, when my family business went out of business and closed down a company and laid off employees, and here is what that looked like."

I have individual providers that come to me and say, "I had a group of files grabbed, not being paid for, that are going through the appeals process and I am fighting my way through that. And

then, as I am fighting my way through that, I had another group of files that was grabbed, and now I am fighting through those, and I am on a different time period and I am not making payroll."

I understand the comment of saying it is 1 percent or it is 2 percent of files, but if they start getting a set grabbed and then 60, 90 days later, another set grabbed when they are still unresolved from the previous one, they are not going to make payroll for these smaller companies. These are very real issues.

We want Medicare providers to be there. We want our seniors to have access. We want individual healthcare folks to know, "If you take care of seniors, the bills will be paid." That certainty is disappearing at this point, and that is a bad formula for where we are 5 years from now, 6 years from now.

That is why the urgency of this is extremely important, that we get ahead of fraud rather than constantly chasing it, because, when we are chasing it, we are also hurting companies that are the good actors that are trying do it right. We are all for shutting down bad actors, aggressively going after that.

But when the good actors made a mistake, made an error, but now they are having a difficult time making payroll on it, we are losing the good guys in this, and that is going to hurt us long term.

So let me shift a little bit.

With the RAC audits—Dr. Agrawal, you and I talked briefly earlier about this—the incentive for them to—if there is a question that this is going to get lost in an appeal, for them to not pull that, for them to actually work with them.

I will tell you—you have probably heard the term as well—many of the hospitals and providers call the RAC audit folks "bounty hunters." They come in, land, go through stuff until they find something, because they get paid based on what they find.

So the incentive is not to be able to sit down with someone and say, "Hey, you made a mistake on this. Let me show you how to do this different." The incentive is, "I got you and I am going to get paid." That is a bad relationship that is forming between our government and the people that we are supposed to serve.

Now we have got to setup environment where the incentive is for them not to work with someone to find and work this out and how to learn on it, but to punitively pull a file. That is a whole different set of relationships there.

So the question is: How do we get back to the incentive with the RAC folks to be helpful rather than punitive, but we still go after fraud?

Ms. King, do you have an idea on that?

Ms. KING. Sir, if I might, the other types of contractors that do post-payment reviews—the MACs, the CERT and the ZPICs—are not paid on the incentive basis. They are paid on the basis of cost under contract. The payments for the RACs were actually established by law——

Mr. LANKFORD. Right.

Ms. KING. —how they were——

Mr. LANKFORD. Correct.

Ms. KING. So that—if you are concerned about the incentives, it is something to consider.

Mr. AGRAWAL. I think that is a very helpful point.

I would also say, you know, we do provide—so I think—let me make two points on this.

One is we do provide oversight to the RACs. So, you know, the characterization that they might be on a fishing expedition or that they are making judgments just to receive the incentive payment is, I think, not accurate because we do, again, do that validation work behind them to make sure their accuracy rate is very high.

That accuracy rate would not be——

Mr. LANKFORD. Is there an incentive to be helpful while they are there, to teach someone how to do this better, or is the incentive to be able to pull it?

Mr. AGRAWAL. I think there is two kinds of incentives that work in the favor of providers.

One is the RACs are equally incentivized to find underpayments to providers. They get the same contingency fee if they return money to a provider that they deserved as they would when they make an overpayment determination. That is just one.

The second thing is we have made it a priority in the program both for RACs and MACs and other auditors to use education as a tool. So when deficiencies are identified, they can communicate those to providers and, hopefully, providers can, you know, rectify that deficiency going forward.

Mr. LANKFORD. Are they—are they paid for that, paid for the education?

Mr. AGRAWAL. Well, the RACs are not specifically paid for that, but the MAC contractors do work very closely with providers in all their regions to, you know, teach them about Medicare policy and payment requirements.

We also utilize the results of both MAC and RAC audits to alter our programs, you know, be more specific on policy issues where necessary, make changes to processes.

So that is a priority for the agency. We do try to use the outcomes of these audits to alter our interactions with providers.

Mr. LANKFORD. So what is the incentive for them to educate?

Mr. AGRAWAL. I think what RACs have been able to do is take areas that we know have high improper payments in them, again, differentiating improper payments from fraud.

Mr. LANKFORD. Right.

Mr. AGRAWAL. RACs are not necessarily designed to go after fraud. Those are other contractors in other areas of work.

What we have asked them to do is focus on areas of high improper payments and make recoveries where appropriate. Along the way, they do identify educational needs or, you know, clarity deficiencies that we can address either through other contractors or directly.

Mr. LANKFORD. Okay.

Mrs. Norton.

Ms. NORTON. Thank you very much. Mr. Chairman, thank you for this hearing.

When—perhaps because Medicare is a necessarily costly program—and I say "necessarily"—we do the best we can to provide the maximum care for the elderly when they are ill—there is particularly concern when there are reports—and they are always

quite sensational—reports of fraud or particular abuses in the program.

I know that the Affordable Healthcare Act gave the CMS several new—or at least expanded authorities to deal with fraud.

And I would be very interested in hearing about how you deal with those at higher risk, who are they, and how you deal with them when they apply—when it applies to providers and suppliers who are newly enrolling and those who want to re-validate their participation in the program.

Mr. AGRAWAL. Sure. Thank you for the question.

So as a result of the Affordable Care Act, we have been required to implement a whole new approach to provider enrollment and screening that takes into account the risk level of that category of provider.

Higher-risk categories of provider, like, say, newly enrolling DME or home health agencies, are subject to greater scrutiny.

That scrutiny can include—or, you know, everybody certainly gets certain data—analytical work to make sure that, you know, providers of all types have the right licensure, have the ability to practice in their provider category.

Higher levels of scrutiny also include site visits, criminal background checks, fingerprinting most recently. As a result of those activities——

Ms. NORTON. Had you done fingerprinting before?

Mr. AGRAWAL. Fingerprinting we are just bringing online. We procured that contractor last month and we are——

Ms. NORTON. For all providers or for the high risk?

Mr. AGRAWAL. The highest-risk providers will be subject to the fingerprinting requirement.

As a result of those activities, we have revoked—and through the re-validation process, we have revoked over 17,000 providers since the ACA and deactivated an additional 260,000.

Ms. NORTON. For example, for what kinds of abuses or fraud—or is it fraud?

Mr. AGRAWAL. All manner of activities. Really, wherever they do not meet our requirements. So lack of appropriate licensure would result in a revocation. The presence of certain felony convictions on criminal background checks would result in revocation. Failure to disclose information required on the Medicare application or to report that accurately.

Ms. NORTON. So would these providers be barred, period, permanently barred?

Mr. AGRAWAL. We—the actions that we take, of course, are governed by the authorities that we have. Revocation allows us to remove these providers for, I think—I believe up to a maximum of 3 years, based on the infringement.

Beyond that, law enforcement has exclusion authority that lasts for longer and is more sort of widespread in its impact, and we do work with law enforcement on utilizing that authority.

Ms. NORTON. Have you had occasion to refer any of these to the U.S. Attorney or other law enforcement?

Mr. AGRAWAL. Yes. We actively work with law enforcement on referrals, but, also, even prior to the referral.

So I think we have given law enforcement an unprecedented access to CMS data, realtime access to our systems, the same that we utilize in our analytical work.

And then, as cases develop, we are in regular connection with law enforcement about cases that they may be interested in and ultimately do make formal referrals that they can choose to accept.

We also work with them on the entire investigational process, as they deem necessary, to provide them additional data or, you know, any assistance that we can.

Ms. NORTON. I am interested in this temporary moratorium. This is apparently a new authority under the ACA for new Medicare providers and suppliers.

What would evoke that? And how does it work?

Mr. AGRAWAL. Sure. So since the ACA, we have implemented essentially two phases of the moratoria essentially against home health agencies—or newly enrolling home health agencies and newly enrolling ambulance suppliers in a few different geographies across the country.

Before implementing that moratorium—this was a big step because it is a—I think a notably important piece of authority that we were granted.

Before implementing it, we worked very closely with law enforcement to make sure we were looking at the right geographies and the right provider types.

We worked with State Medicaid agencies and across the Agency, across CMS, to ensure that we are going after the right areas and, also, not having—or potentially would have a deleterious effect on the access to care.

Well, we ultimately chose both the geographies and the provider types were markets that were saturated by these provider types, roughly, 3 to 5 percent higher market saturation in home health agencies and ambulance suppliers than the average, you know, geography across the country.

So far, the moratoria have been in place for—the first phase was put in in July of last year, a second phase in January. We continue to monitor both cost issues as well as access to care, and we have not noted any access issues thus far.

I would say the moratorium has been a useful tool. I believe law enforcement finds it a useful tool as, essentially, a pause in the program so that no new providers enter a geography and bad actors can meanwhile be rooted out.

Just as examples of work that we have done, we have revoked over 100 home health agencies in Miami alone, more than half of those during the moratorium period, and 170 revocations of ambulance suppliers in Texas.

Ms. NORTON. Now, how do you keep beneficiaries from being affected, particularly with that large number in one location?

Mr. AGRAWAL. Right. That is absolutely a priority of ours. We started by choosing areas that were very saturated to begin with. These are not areas where access to home health services or ambulance services was threatened in any way. Even MedPAC had agreed that both of these provider types, as well as the geographies, were appropriate to go after.

Since implementing them, we have, you know, stayed in constant contact with the specialty societies that oversee these areas.

We have worked with State Medicaid agencies, with CMS regional offices that directly receive complaints from either providers or beneficiaries, to monitor for access-to-care issues. And as I stated earlier, we have not identified those issues so far.

Ms. NORTON. Finally, Ms. King, have you had occasion, since these are new authorities, to look at their effectiveness and their implementation?

Ms. KING. We have not. We evaluated the enrollment process just as these new authorities were going online, but we have not been back to look at it yet.

But we concur that front-end strategies on the enrollment side—that making sure that the right providers are enrolled and the ones that are at risk for being fraudulent are prevented from being enrolled is a very effective strategy.

Ms. NORTON. Thank you very much.

Mr. LANKFORD. Let me just run through some quick questions, and then we are nearing the end. So the end is near.

I want to confirm again the percent of patient files pulled for a RAC audit. You have used the 1 percent number several times. Is that accurate, around 1 percent, or you say 1 percent or less?

Ms. KING. The 1 percent actually is not just the RAC audits. It is all the post-payment audits.

Mr. LANKFORD. Okay. That is in every category, whether that be durable medical equipment, physical therapy, hospitals, labs, whatever it may be? In every category, it is 1 percent or less?

Ms. KING. Yes.

Mr. LANKFORD. Okay.

Ms. KING. Well, the aggregate number is less than 1 percent.

Mr. LANKFORD. That is what I am asking——

Ms. KING. Yes.

Mr. LANKFORD. —for each category.

Are there categories that are higher—that are considered more high risk and, so, there are more that are pulled in in that category?

Ms. KING. I don't know the answer to that.

Mr. LANKFORD. Do you, Dr. Agrawal?

Mr. AGRAWAL. I can't answer the claim question. But in terms of prioritization, we clearly do focus on high improper payment rate areas.

I think that is a requirement of the contractor itself, of the program, that we focus on areas where the improper payment rate is just much higher than in other areas.

So you would expect to see a greater portion of audits in, say, for example, durable medical equipment or home health agency services because those are where a lot of the improper payments are——

Mr. LANKFORD. That is what I am trying to figure out.

Is that category higher than 1 percent of what is pulled?

Ms. KING. You know, we can look into this. But I believe that most of the RAC audits are focused on the part A side, even though that the rate—the rate of improper payments is higher in durable

medical equipment and home health providers, but the actual dollar amounts of the improper payments are higher——

Mr. LANKFORD. Sure.

Ms. KING. —on part A.

Mr. LANKFORD. Where you have larger bills, whether it is part A, it is going to be larger than what is going to be in part B and most of the smaller providers. So I would understand that, but it may be large to them.

So if you have got a—again, going back to the physical therapy clinic, privately owned, fewer number of patients there, it may be a very big deal to them to have 2 percent of their files pulled than it would be to a hospital, as far as just general overhead.

Okay. Dr. Agrawal, you mentioned as well about good actors in this, the possibility—and I heard a lot of, you know, variances of that to put it in the maybe is possible. You know, we are looking at statements in it for good actors that are out there.

Once they have gone through, they have proved it to do well, they didn't have a lot of inaccuracies, how do we slow down the process so they are not coming just as fast to them, again, coming to, again, an entity that is set up to do compliance now more than it is to take care of people? Where are we on that? Give me the process.

Mr. AGRAWAL. Sure. So one solution that has been proposed is to lower the volume of medical record requests that could go to a provider that in previous requests has actually had a low denial or overpayment determination rate.

That, I think, is a good idea. We have heard it from a number of sources, and we are implementing that approach in our next round of RAC contracts precisely so that providers that have been audited, that have done well in the audits and shown that they are following the rules will face fewer audits and lower volumes going forward.

Mr. LANKFORD. Okay. Is that less frequency of audits or is that they are grabbing a smaller number of files when they come, they are coming just as often, they are maybe just doing half of 1 percent rather than 1 percent, or are they coming maybe only once every 2 years so they are in their building less often?

Mr. AGRAWAL. I would have to confirm. I know the volume, you know, per audit will be decreased, but I have to confirm if the frequency would also be——

Mr. LANKFORD. Okay. I would just recommend to you both are important, especially to part B folks. They are trying to run a business and, if they prove to be good actors in this, the frequency matters to them.

When they have to stop—now, obviously, the volume that is being withheld from them, not being paid to them, makes a big difference for them making payroll.

But it is also extremely important they are able to focus on their business and not every 60 days, 90 days, have to stop and do another one of these if they have already proven they are doing well, they are following the rules.

So I would recommend to you both, both frequency and number of files that they are pulling.

Has there been a study to look at the compliance costs for the providers?

Mr. Ritchie, you mentioned before around $700 million has been recovered this year. Is that correct?

Mr. RITCHIE. Yes.

Mr. LANKFORD. Okay. Do we know what the compliance cost is? Has anyone seen a figure for that?

Ms. KING. Not to my knowledge.

Mr. LANKFORD. Because in most of the regulations that are out there, when they are promulgated, there is an estimated compliance cost for the promulgation of the rule it has to go through, based on the number of requirements.

The question is: Do we now know with more certainty what the actual compliance cost is? Where would I get that?

Ms. KING. I am not aware that such a study has been done. We have not done one.

Mr. LANKFORD. Okay.

Mr. RITCHIE. We haven't either. I am not aware of it.

Mr. LANKFORD. Okay. I can go back and look at the beginning because, when it was originally promulgated, there would have had to have been an initial estimate that was put out at that time as well.

I'll go back and pull that. We'll work through that on our side, since we don't know of another one that has been done since then.

Then last set of questions here on this.

The pausing of the RACs. Administrator Tavenner and I have had a conversation that, when there is an intermediary change, very typically when the intermediary changes to a new one, what happen is the old intermediary starts losing employees quickly and they are trying to still maintain all the RAC audits during that time period with fewer and fewer staff, but everyone is leaving because that company is shutting down or shifting to a different spot.

The other company is still trying to fire up and to be able to get ready. So it is very slow. But the speed of RACs can be the same across that, though the old intermediary can't keep up and the new intermediary can't keep up and you have got a drag there in response time.

So my conversation has been, "Can we reduce the number of RACs during that transition time when the intermediary changes?"

If the authority exists to do that, where is the authority to also slow down the process to allow us to catch up on this backlog somewhat, to look at it and say, "We are still going to continue to do this. We have got to slow this down"?

Because if we are approaching a million files sitting out there with more still coming, they will never catch up. It doesn't matter how much we fund it. We are not going to catch up. And that is a lot of money to be held from individuals.

What is the conversation out there related to that?

Mr. AGRAWAL. Yeah. So we do realize that, as we procure the next round of RAC contractors, that there is a sort of transition issue.

What we have done is paused the RAC program during this transition. What we don't want to happen is for one contractor to ini-

tiate an audit and for a second contractor to then complete that audit.

So we are working——

Mr. LANKFORD. Happens all the time.

Mr. AGRAWAL. —we are working to avoid it this time.

So the last round of audits were initiated—or were permitted to be initiated at beginning of February. Those audits must be completed in a timely manner so that—and then the RACs—the current batch of RACs can wind down and then the new batch of RACs can wind up.

During this pause, we are also, you know, using it to—taking advantage of it to alter the RAC program based on input that we have gotten from providers and other stakeholders to make it more transparent to providers, to provide more education and to make sure that it is focused on all areas of improper payment.

Mr. LANKFORD. And when will that be public?

Mr. AGRAWAL. The procurement process is going on right now. We are following, you know, sort of standard Federal procurement requirements.

There are statements of work that I—you know, in order to be—to actually get proposals that either have hit or will soon hit, you know, public transparency and contractors will be able to respond to.

Mr. LANKFORD. Okay. Any other final comments?

Well, I appreciate——

Ms. KING. No, sir.

Mr. LANKFORD. Okay. I appreciate you being here and for the conversation. Your work is extremely important both in transparency and in helping us deal with improper payments and fraud.

But I think you have heard from this committee pretty clearly we need a balance. We need providers. Right now with what is happening in healthcare across the country, we are losing providers, and anything that discourages a provider from continuing to stay open makes the problem worse.

We have more seniors every day joining into Medicare, and we have a problem with providers staying in, based on reimbursements and based on just sheer compliance and the frustration of that.

This is reaching a really bad spot, and we have got to make sure we are working with providers to keep the good actors and then weed out the bad actors and educate those that just made a mistake rather than push them out of business.

So, with that, we are adjourned.

Ms. KING. Thank you.

Mr. AGRAWAL. Thank you.

[Whereupon, at 12:01 p.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

American Orthotic & Prosthetic Association

Statement of the American Orthotic and Prosthetic Association on Combating Fraud, Waste, and Abuse in the Medicare Program
Oversight and Government Reform Subcommittee on Energy Policy, Health Care and Entitlements
May 20, 2014

The American Orthotic and Prosthetic Association (AOPA) is pleased to provide this statement concerning Medicare fraud and the delivery of care to Medicare beneficiaries who have suffered a loss of a limb or impaired use of a limb or the spine. AOPA, founded in 1917, is the largest orthotic and prosthetic trade association with a national membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss or limb impairment resulting from a chronic disease or health condition. Members include patient care facilities, manufacturers and distributors of prostheses, orthoses, and related products, plus educational and research institutions. The field of providing artificial limbs or customized bracing for those Medicare beneficiaries with limb loss or limb impairment is a highly specialized area representing a small, roughly one-third of 1 percent, slice of Medicare spending but has a huge impact on restoring mobility to those patients served. A replacement limb may mean the difference between returning to work and a former life quality and remaining an active and contributing member of society. Customized orthotic bracing solutions for chronic conditions may have a similar long range impact.

Annual Medicare spending for custom orthotics and all prosthetics (O&P) is less than one percent of all Medicare spending. However, Medicare fraud has an outsized impact on the beneficiaries whose limb loss or impairment results in the need for orthotics or prosthetics. Patients treated by AOPA's members already are confronted with the trauma of limb loss or impairment, loss of mobility, diminished independence, and sometimes financial hardship. When seen by a fraudulent supplier, the patient also oftentimes experiences a financial loss after paying for a device that is inappropriate or never delivered. Additionally, a patient in this situation has to find another supplier and make another copayment, and he or she may lose important time in the rehabilitation process. According to research of health economics and policy consulting firm, Dobson-DaVanzo, nearly one-third of the $3.62 billion CMS paid between 2007-2011 for O&P services for Medicare beneficiaries went to unlicensed providers, as well as those who fail to meet the accreditation requirements mandated in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Additional research by Dobson-DaVanzo tracking Medicare data has demonstrated the overall cost-effectiveness of O&P care. For example, the analytic work indicated that over the first eighteen months patients who receive spinal orthoses had total Medicare episode payments that were 0.3% lower than those who did not receive orthotic bracing for the comparable back ailment. These are important trends for saving Medicare dollars.

AOPA and its members believe the best way to fight fraud in the O&P sector is to prevent fraud in the first place. We also believe that it is possible – and preferable – to combat fraud without punishing an entire healthcare sector because of the actions of a handful of bad actors. Regrettably, it seems that the Centers for Medicare and Medicaid Services (CMS) has opted for the latter approach, despite Congress having given the agency adequate authority to drive fraudulent suppliers from the Medicare program.

The Fraud-Fighting Tools CMS Has Not Used

BIPA section 427 requires CMS to ensure that Medicare payments for custom fabricated orthotics and all prosthetics are furnished by "qualified practitioners" and "qualified suppliers." The O&P profession supported this effort and consistently has pushed to have this requirement implemented. Currently, 16 states have enacted O&P licensure statutes. In 2005, CMS issued Transmittal 656 to Medicare payment contractors specifying that contractors must have claims processing edits in place to make sure that in those states where O&P must be provided by a licensed orthotist or prosthetist, payments are made only to practitioners and suppliers that meet relevant state O&P licensure laws. However, CMS has not taken concrete steps to enforce this requirement. For example, in 2009, a "60 Minutes" expose demonstrated that CMS was paying unlicensed providers for O&P services. The amount of Medicare funds inappropriately paid by CMS was in the tens of millions. The fraud discussed in that report involved the state of Florida, which has O&P licensure requirements.

Since Congress passed BIPA, AOPA and its members have met with CMS administrators and staff regarding implementation of the law, and in 2007, we were told that proposed regulations would be issued by the end of that year. We are still waiting. On June 25, 2013, AOPA shared with CMS the results of two studies that demonstrate that CMS had been paying unlicensed suppliers.

- In one study, Dobson-DaVanzo examined Medicare claims data from 2007-2011 and did not find significant changes in the distribution of payments to medical supply facilities with uncertified O&P professionals on their staffs. We note that orthotist and prosthetist licensing requirements in most states track very closely with the typical certification requirements of training and education so that a person who is not certified will almost never meet eligibility for licensure. It is possible to be certified and not licensed, but it is virtually impossible to be licensed and not certified.
- In the other study, conducted in 2013, orthotics and prosthetics suppliers who were receiving Medicare payments were contacted in three licensure states (FL, OH and TX) and asked if they had a licensed O&P professional on staff. This study revealed that 65 out of 78 surveyed suppliers by their own admission did not have a licensed professional on staff.

In a letter to AOPA dated August 2, 2013, CMS Administrator Marilyn Tavenner denied that CMS has been paying unlicensed O&P suppliers. In the letter, Administrator Tavenner states that systematic claims edits have been in place since 2005 to deny claims submitted by unlicensed suppliers in nine states with O&P licensure requirements (AL, FL, IL, NJ, OH, OK, RI, TX, and WA) and that the agency is implementing claims edits for the remaining five states with licensure requirements (AR, GA, KY, MS and TN). This was reported in a Medicare Learning Network Matters article on the same day. This amounts to an admission by the agency that it has been paying unlicensed suppliers in at least five licensure states (and CMS has omitted any reference to Pennsylvania and Iowa, both of which have enacted O&P licensure as well). Also, the effectiveness of the claims edits in the other nine states is questionable, in light of the fraud that has been documented in two of these states (FL and TX) since 2005 when these edits reportedly were implemented.

It is difficult to understand how the relative proportion of Medicare payments to non-certified orthotics and prosthetics suppliers is unchanged if unlicensed providers no longer are receiving payments in states where certification is required. We have seen evidence of only a small reduction in the proportion of payments to non-certified O&P personnel since 2009. This also is supported by the results of the independent survey of orthotics and prosthetics suppliers, which showed that unlicensed, non-certified suppliers continue to provide and be

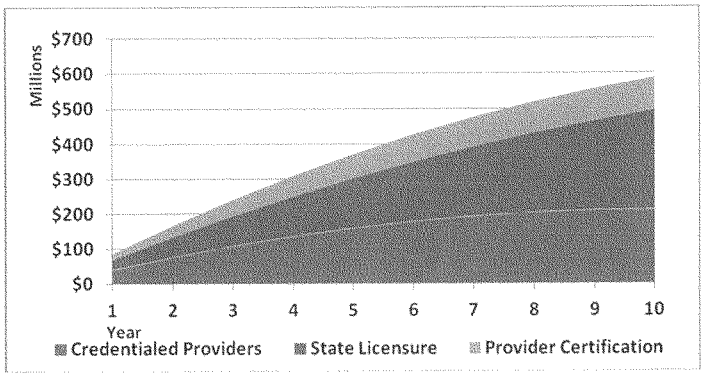
paid for orthotics and prosthetics furnished to Medicare beneficiaries, even in states where licensure is required.

H. R. 3112, the Medicare Orthotics and Prosthetics Improvement Act of 2013, has been introduced in Congress and would build upon the fraud-fighting provisions included in BIPA. It would help reduce fraud, protect patients, and save Medicare funds by keeping out fraudulent providers in the first place. As the Dobson-DaVanzo report notes: "If CMS was to actively enforce that unlicensed providers cannot receive payment for providing orthotics and prosthetics services to Medicare beneficiaries within a licensure state, Medicare savings could be realized. Under such enforcement of limiting payments to providers with proven licensure and standards of training and experience, payments to unqualified providers would be eliminated. As the '60 Minutes' special suggested, allowing non-certified/unlicensed personnel to provide these services, especially in states with licensure, could lead to fraud and abuse in orthotics and prosthetics services, as well as expose patients who received these services to inappropriate or substandard care. Therefore, shifting payments to only certified providers could result in better care for beneficiaries and lower Medicare payments." An estimate of how much could be saved by implementation of these provisions is provided in the following excerpts from a 2009 report prepared by Morrison Informatics.

Table 1 – First Year Medicare Savings Estimated Range Following H.R. 2479 (now H.R. 3112) Provisions, with Amendment (in millions)

Provision	Medicare Savings Range	Proportion of Savings
Credentialed Providers	**$40 - $101**	**47%**
State Licensure	**$28 - $71**	**33%**
Provider Certification	**$18 - $44**	**20%**
Total	**$86 - $216**	**100%**

Figure 1 – Minimum Cumulative 10-Year Medicare Savings Projection Following H.R. 2479 (now H.R. 3112) Provisions, with Amendment



Concerns about CMS' failure to implement BIPA Section 427 were brought to the agency's attention most recently in a letter from the Chair of the House Ways and Means Committee and the Chair of the Committee's Health Subcommittee. CMS's response, dated March 6, 2014, stated that CMS is developing a notice of proposed rulemaking and anticipates that it will be published in 2014. AOPA is skeptical, since we have been told by Ms. Tavenner and other CMS administrators in the past that proposed regulations were forthcoming. In its response, CMS also said that "when a state has enacted a new licensure law, CMS implements an edit that immediately limits payment to only those suppliers that have a specialty of O&P on their enrollment applications. Then the [National Supplier Clearinghouse] determines whether all O&P suppliers in the affected state have the required licenses or certifications." However, the National Supplier Clearinghouse generally scrutinizes a potential O&P supplier only when the supplier seeks a new Medicare provider number and on a regular three year re-enrollment cycle thereafter. AOPA is not aware of actions taken by National Supplier Clearinghouse to monitor O&P suppliers for licensure after granting a Medicare number.

In summary, CMS currently has several tools at its disposal to bolster its efforts to fight fraud in the orthotics and prosthetics field, yet it has failed to avail itself of its full arsenal. It has not issued any regulations to implement Section 427 of BIPA, and edits to prevent payment to unlicensed orthotics and prosthetics suppliers have not been implemented fully. These shortcomings were highlighted by the HHS Office of Inspector General in its October, 2012 report entitled, "CMS Has Not Promulgated Regulations to Establish Payment Requirements for Prosthetics and Custom-Fabricated Orthotics," but still no rules have been promulgated.

RAC Audits and the ALJ Appeals Backlog

Instead of using tools to keep bad actors from participating in the O&P sector, CMS has ramped up the Recovery Audit Contractor (RAC) program, which has had the effect of punishing legitimate providers.

While CMS makes payments to unlicensed and unaccredited providers, contravening Congress's intention, legitimate suppliers have been subject to RAC and prepayment audits conducted by contractors who appear to play by their own set of rules. It also appears that RAC audits penalize suppliers for paperwork or documentation errors as often, or more often, than it catches those perpetrating fraud. This sometimes results in legitimate

providers, especially those who are small businesses, suffering cash flow problems or going out of business. AOPA estimates that roughly 100 orthotics and prosthetics suppliers have gone out of business within the past eighteen months, at least in part due to these audit/recoupment related cash flow problems. The impact of these closings extends beyond economics and business—it directly and negatively affects individuals with limb loss, as they have been deprived of long-standing, clinically-beneficial relationships with their health care providers. We note that AOPA has sued the U.S. Department of Health and Human Services (HHS) over RAC audits and how they are being applied to O&P suppliers.

We feel that certain actions by CMS have compromised the due process rights of O&P suppliers. For example, CMS issued a "Dear Physician" letter on its website in August, 2011 that had the effect of establishing new policy for payment for artificial limbs, and it applied the new policy retroactively in RAC and prepayment audits as to claims for dates of service as much as two years before the policy was issued in the letter.

There has been an explosion in the number of RAC audit claims under Medicare Part B for artificial limbs that are appealed to the Administrative Law Judge (ALJ) level. Congress and CMS have provided some modest relief for Medicare Part A providers, but none of this relief has been extended to Part B claims for artificial limbs. While we appreciate the difficult task facing the Office of Medicare Hearings and Appeals (OMHA), timely redress of improperly denied payments is critical. Many suppliers, particularly in the O&P field, are small businesses that do not have the luxury of waiting months for payment of services legitimately furnished. In fact, just last year, 35 Members of Congress wrote to HHS Secretary Kathleen Sebelius that well-intentioned efforts to reduce fraud and abuse in Medicare may be harming access for vulnerable Medicare beneficiaries and placing undue burdens on legitimate O&P providers. In a context of increasingly aggressive CMS audits, OMHA's decision to suspend ALJ review of provider and supplier claims is devastating to suppliers who deliver Medicare services to over 40 million beneficiaries.

Congress showed that it understood the importance of timely processing of Medicare appeals when it included in BIPA a requirement that an ALJ issue a decision about a case within 90 days of the date when the appeal request was filed. However, by OMHA's own admission, the current wait time for a hearing before an ALJ has increased to 16 months. In some areas that wait is as long as 26 months, which is unacceptable.

At the February 12, 2014 OMHA public hearing on this issue, Judge Griswold gave an explanation of OMHA's position, but offered few if any short-term remedies that would restore the right of a timely ALJ hearing to providers. With ALJs siding fully with appellants in over half of all decisions, ALJ hearings realistically amount to a provider's primary means of challenging costly and often prejudicial CMS auditor decisions. As OMHA is leaving Medicare providers without an avenue of redress against auditors' payment denials, we believe it is only fair that CMS suspend these audits until an appropriate, timely, and statutorily required system providing due process to providers is restored.

H.R. 3112 Is a Strong Positive Step in Fighting Fraud; Surety Bonds Are Not an Answer to Fraud—They Punish All Legitimate Medicare Providers, Without Posing Any Significant Impediment to Unscrupulous Actors Who Perpetrate Medicare Fraud

Effectively fighting Medicare fraud requires implementing truly effective measures aimed at stopping unscrupulous actors and saving Medicare dollars, as in H. R. 3112, the Medicare Orthotics and Prosthetics improvement Act of 2013, enactment of which could avoid pointless or misdirected steps like RAC and Pre-payment audits about paperwork "gotchas" that have little or no relationship to preventing actual fraud. One such misdirected effort has been CMS' imposition of surety bond requirements on all providers. These bonds add substantial costs to all legitimate providers, including substantial new financial burdens on small business O&P facilities, but do nothing to distinguish legitimate from fraudulent providers—a fraudulent provider who

pays the surety "toll" to support its enterprise of bilking Medicare then continues to receive Medicare payments unabated. It is a small, insignificant barrier to Medicare scammers, but it is another financial setback for honest providers.

A key provision of H.R. 3112 would simply require CMS to implement BIPA section 427, which requires CMS to only make payments to "qualified providers," as those professionals certified by the two main certification organizations, or their equivalent, in the field of O&P or properly licensed in those states requiring licensure. Unlike surety bonds, this constitutes a long-term solution.

Another long-term solution provided by H.R. 3112 is the linking of eligibility for payment to the qualification of the providers and the complexity of the device the patient needs, which improves alignment between patients and providers. Additionally, taxpayer dollars would be saved through a reduction in poor outcomes and repeated charges for follow up O&P care that would not be necessary if a qualified provider had served the patient in the first place.

Legislative Efforts Relating to Limiting the In-Office Ancillary Care Exception to Stark Self-Referral Rules

AOPA has noted that the Committee on Ways and Means Subcommittee on Health Ranking Minority Member, Rep. McDermott, has introduced a bill aimed at eliminating the exception to the Stark self-referral provisions for in-office ancillary services. AOPA supports this new legislation in principle. The Orthotic & Prosthetic Alliance in recent months has communicated concerns to OIG about how, in the context of physician-owned distributorships (PODs), the in-office ancillary services rule sometimes operates and results, at least as it relates to O&P, in increases of the number and value of services which the patient does not need, thus costing Medicare taxpayer dollars. However, no substantive action was taken. This provision has also prompted state legislative issues in states like Texas where it has been used by special interests to try to expand the prospects for payments to unqualified or under-qualified providers.

Prior Authorization is Not an Answer for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The topic of prior authorization in terms of Medicare is a complex one, and in applying the concept to RAC audits, CMS has unfortunately only seen cookie-cutter models. Therefore, two years ago, when CMS observed that a demonstration project in prior authorization was acceptable for power wheelchairs (PME) in DME, it was inappropriate to believe the same approach would solve the O&P audit issues the same way. When applied to custom-fabricated O&P devices, prior authorization does not represent an improvement over the current RAC model for either providers or patients.

First, a major flaw is that Medicare Prior Authorization is NOT a promise of payment. Absent a payment guarantee, providers are subject to the same delays and denials currently imposed by RACs. Therefore AOPA and the vast majority of its patient care facility members oppose it as any kind of 'solution' to audits.

A second major problem is that, in reality, the PME demo project resulted in longer delays for patients. CMS insists the numbers are shorter, but reliable reports estimate that it takes between 70-100 days from the date the physician orders a power wheelchair until the prior authorization goes through and the power wheelchair reaches the beneficiary. That kind of delay simply doesn't work for the care of amputees—who actually experience less delay under the current broken RAC regime. Prior authorization may have worked, but only for a few limited cases in the private sector, and only if it is an absolute guarantee of payment (otherwise, it creates its own cash flow problems). That is not true in Medicare. CMS would be severely challenged to implement prior authorization.

Concepts That Will Work in Restoring Sanity to RAC and Pre-Payment Audits of Claims for Part B Artificial Limbs for Medicare Amputees

Following are proposals from the Orthotic & Prosthetic Alliance to reform RAC and prepayment audits of Part B claims for artificial limbs. These are steps that definitely would assist in restoring fairness, transparency and due process as well as greatly reducing the devastation RAC and prepayment audits by CMS contractors has caused Part B claims for artificial limbs for Medicare amputees. They include:

a. Establish the prosthetist/orthotist's notes as a legitimate component of the patient medical record, comparable to a therapist;

b. Establish the prosthetist/orthotist as a recognized Medicare provider of care, distinguished from treatment as a DME supplier—the distinction between O&P and DME is clear both as O&P providers assume the role of lifetime mobility health professionals as well as being reflected in the much higher success rate when O&P appeals are decided at the ALJ level;

c. Remove the Qualified Independent Contractor (QIC) stage of the appeals process, since it takes time and virtually never results in a favorable decision for the O&P provider;

d. Advance the appeal more expeditiously to the ALJ for final action;

e. Mandate that CMS compile data on audit appeals for O&P only, separate from DME which is needed to track both the very high rate O&P RACs audit appeals and high overturn rate on appeal (CMS has consistently refused to track such data)*;

f. Establish financial penalties for RACs if an established percentage of appeal overturns occur, e.g. double interest penalties assessed against RAC, which funds along with savings from item C. above could be used to fund an increase in the number of ALJs; and

g. Address the need for more ALJs to mitigate the current backlog, either by direction to the Office of Medicare Hearings and Appeals (OMHA), which as an arm of HHS is responsible for funding for ALJs, or a statutory change to instruct CMS to fund ALJ appeals for RAC determinations.

* It was underscored in the May 20 hearing before the Oversight and Government Reform Committee that overturn rates at the ALJ level run between 56% to 74% provider success in overturning RAC audit conclusions.

Unlike Part A, There Has Been No Pause or Any Relief Whatsoever from CMS as to Part B RACs.

AOPA applauds the Congress' search for a longer term solution for hospitals as those solutions in part will help address or inspire solutions for the similar audit problems facing O&P providers. Many suppliers affected by RAC audits are small businesses like our members. They do not have the financial wherewithal to sustain their business when RAC audits or other questionable tactics to fight fraud and abuse continue unabated. It would be our hope that the focus of these hearings on the needs of our nation's hospitals under Part A becomes the clarion call for expanding solutions to relieve the threatening disasters that will befall small business providers under Part B if early and significant relief from Part B RAC audits is not forthcoming.

Many, including members of Congress, see the Part A relief for hospitals in terms of the "pause" for about a year relating to RACs under the two midnight rule, and think there has been similar relief under Part B for O&P RAC audits--the truth is that there has been no pause or any relief whatsoever from CMS as to Part B RACs.

Conclusion

In conclusion, AOPA wants to continue to work with Congress and CMS to ensure that those who prey on Medicare beneficiaries do not find the O&P sector an easy place to establish and operate a fraud scheme. We offer our support for developing more effective means to fight Medicare fraud that does not punish legitimate suppliers who are playing by the rules. We believe that the fairest and most effective system is one that

prevents fraud before it starts, and we hope that Congress will direct CMS to develop a system taking the pathways outlined in both BIPA section 427 and H.R. 3112 to deter fraud, promote program integrity and protect the due process rights of legitimate orthotics and prosthetics health professionals.

AOPA appreciates the efforts of the Chairman for working with us to find ways to better regulate our payments. We hope to continue to work with you to improve the quality of care we deliver to patients who need O&P services, and to protect the integrity of the Medicare program.

Questions for
Shantanu Agrawal, M.D.
Deputy Administrator and Director
Center for Program Integrity
Center for Medicare and Medicaid Services

Committee on Oversight and Government Reform

Hearing: "Medicare Mismanagement:
Oversight of the Federal Government Efforts to Recapture Misspent Funds"

Chairman James Lankford

1. **When a Recovery Audit Contractor (RAC) contacts a provider to conduct an investigation, what percent of patient files are they allowed to pull for an audit? What sampling limits are imposed by the Centers for Medicare and Medicaid Services (CMS)? Please verify your responses with supporting data. Does the percentage of files pulled change based on provider type? Does the percentage of files pulled change based on provider size?**

Answer: CMS is sensitive to the concerns of the provider and supplier communities and continues to work with these communities to reduce the burden of the review process. CMS has imposed additional documentation request limits on the number of medical records a Recovery Auditor may request in a 45-day timeframe. The limits establish continuity and help providers prepare for potential audits, as well as encourage the Recovery Auditors to select only those claims with the highest risk of improper payment. CMS posted the additional documentation limits online.[1] The limits are based on the size of the provider and there are separate limits for physicians, suppliers, prosthetists and orthotists and hospitals and other Part A providers.

In addition, CMS announced a number of changes to the Recovery Audit Program[2] in response to industry feedback including establishing revised additional documentation requests (ADR) limits that will be diversified across different claim types (*e.g.,* inpatient, outpatient). CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits. These changes will be effective with the next Recovery Audit Program contract awards.

[1] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Provider-Resource.html
[2] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf

2. Does CMS coordinate the efforts of contractors to ensure that providers are not inundated with document requests for payment reviews? How does CMS coordinate this effort?

Answer: CMS has processes in place to ensure that contractor work is collaborative and not duplicative. A claim that has been reviewed by one entity is not available to another entity for review, absent potential fraud or for error rate estimation processes. Any claim or provider currently being reviewed for potential fraud is usually not available for review by a Recovery Auditor and the contractors work together to ensure they all are not reviewing the same issues for the same providers. CMS is continuously working to improve the collaboration between auditing contractors to ensure accurate and efficient auditing of Medicare claims while reducing provider burden and ensuring beneficiary access to health care/health services.

CMS is exploring additional options to help providers navigate through the audit process. Initiatives include enhancing CMS websites with consolidated contractor information, standardizing documentation request letters, and standardizing medical review timeframes. CMS understands that some providers utilize additional staffing to help manage the requirements of the Recovery Audit Program and is constantly working to streamline program operations as much as possible.

3. What role does CMS have in determining the types of claims that RACs will investigate?

Answer: CMS has implemented several elements to ensure Recovery Auditors are accurately identifying improper payments. All new review topics for potential audits are approved by CMS before the Recovery Auditors begin widespread review. For complex non-coding reviews, this occurs through a CMS New Issue Review Board that is comprised of CMS policy and coverage staff and clinicians. This ensures that the appropriate CMS personnel both, are aware of, and approve of, what the Recovery Auditors are reviewing, and that they have the correct interpretation of the policies used in their audit methodologies. During CMS New Issue Review Board meetings, coverage and policy experts review whether the Recovery Auditor's proposed review approach is consistent with current guidelines. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate. This leads to changes in updating certain coverage or billing guidelines to align with more current practice.

For other types of reviews, such as automated, semi-automated, and complex coding, CMS uses the expertise of the MACs to review potential review topics and make recommendations to CMS regarding approval. This ensures that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies in their region.

4. What quality measures does CMS have in place to ensure that contractors are conducting their audits according to CMS requirements? Does CMS have performance metrics in place? If so, please describe these metrics. Does CMS utilize these metrics when determining future contracts?

Answer: To ensure the accuracy of the Recovery Auditor's claim determinations, CMS uses an independent validation contractor to review a monthly random sample of claims on which the Recovery Auditors has made an improper payment determination. The Recovery Audit Validation Contractor (RVC) establishes an annual accuracy score for each Recovery Auditor. The RVC employs policy experts and clinicians, and presents CMS with an independent decision regarding the sample. The accuracy score represents how often the Recovery Auditors were accurately determining overpayments or underpayments based on the validation contractor's review. In Fiscal Year (FY) 2012, all Recovery Auditors had a cumulative accuracy score of 92 percent or higher.[3]

The RVC is also tasked with conducting special studies of Recovery Auditor findings. In FY 2012, the validation contractor performed 14 special studies on claims reviewed by all four Recovery Auditors. CMS uses these studies to further focus on certain claim types and audit areas that may require more analysis. Including both the accuracy and special study reviews, the RVC reviewed over 5,000 claims as part of its oversight activities.

CMS regularly evaluates the Recovery Auditors' performance and adherence to the requirements in their Statement of Work. Staff members go on location to observe medical reviewers, IT systems, and customer service areas. When onsite visits are not possible, CMS conducts desk audits on claims to confirm that all aspects of the review process were completed correctly and accounted for in the Data Warehouse. Regular meetings with claims processing contractors, provider groups, and other stakeholders are also monitored for additional contractor oversight. If there are any findings in these evaluations, CMS notifies the Recovery Auditor and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the Contractor Performance Assessment Rating System for an overall performance rating for the year. These results are available to all 20 Federal agencies. CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program.

5. Are there consequences for RACs when claims they identify as "improper" are found to be appropriately made?

Answer: Section 1893 of the Social Security Act requires CMS to use Recovery Auditors to identify and recoup improper payments in the Medicare program. CMS has many safeguards in place to ensure Recovery Auditors are not financially incentivized to inappropriately deny claims. For one, if the claim is overturned at any level of appeal, the Recovery Auditor does not receive a contingency fee payment. The majority of Recovery Auditor determinations are never appealed. In FY 2012, only 26.3 percent of all determinations were appealed at any level. When Recovery Auditor determinations are in fact appealed, many of these decisions are upheld. For

[3] See: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf (Appendix K)

FY 2012, the Recovery Audit program experienced a seven percent overturn rate. CMS also contracts with an independent entity that reviews a random sample of claims from each Recovery Auditor to establish an accuracy rate, which is a measure of the accuracy of each Recovery Auditor's overpayment and underpayment determinations. The combined accuracy rates for the Recovery Auditors are consistently above 90 percent.

In addition, continued poor performance by a Recovery Auditor will result in negative performance evaluations and may result in work stoppage, corrective action plans and/or contract modification or termination.

6. **How many requests for documents did CMS contractors make for post-payment reviews in Fiscal Year 2013? How many of these requests were for Part A hospital claims? Other Part A claims? Part B claims? DMEPOS claims? What percentage of total Medicare claims, by claim type, does this represent? How many of these reviews resulted in an identified improper payment?**

Answer: Medicare processes approximately 1.1 billion claims per year. Less than one percent of all Medicare FFS claims are subject to medical review.

In FY 2013, the Fee-for-Service Recovery Auditors completed post-pay complex review on 1,294,792 claims. Of those 510,607 were found to contain an improper payment.

The Medicare Administrative Contractors (MACs) focus mostly on pre-payment complex review in order to prevent improper payments.

In FY 2013, the A/B MACs conducted complex post-pay reviews on 56,467 claims and denied 31,058 of those claims.

The DME MACs conducted complex post-pay reviews on 674 claims and denied 420 of those claims.

To comply with the Improper Payments Information Act of 2002 (IPIA) as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination & Recovery Improvement Act of 2012 (IPERIA), CMS performs post-payment review on approximately 50,000 claims to estimate the amount of improper payments in the Medicare FFS program. In 2013, the improper payment rate was 10.1 percent, representing an estimated $36.0 billion in improper payments.

7. **Has CMS conducted any estimates on provider compliance costs for responding to post-payment review audits? Please provide these estimates?**

Answer: CMS does not maintain data of provider expenditures for Recovery Audit Program reviews; however, we are highly committed to working with the provider and supplier communities and other stakeholders to improve the program and refine ongoing operations. For example, CMS' Division of Recovery Audit Operations meets monthly with the American Hospital and Medical Associations to update the associations on program activities, and discuss

the associations' ideas to help reduce administrative burden and program associated costs for providers. It is also helpful to remember that in cases where the Recovery Auditor finds that a provider has fully complied with the Medicare rules, they will cease auditing that provider.

CMS is sensitive to the concerns of the provider and supplier communities and continues to work with these communities to reduce the burden of the review process. CMS has imposed additional documentation request limits on the number of medical records a Recovery Auditor may request in a 45-day timeframe. The limits establish continuity and help providers prepare for potential audits, as well as encourage the Recovery Auditors to select only those claims with the highest risk of improper payment.

CMS posts the additional documentation limits online.[4] The limits are based on the size of the provider and there are separate limits for physicians, suppliers, prosthetists and orthotists and hospitals and other Part A providers.

8. **Please share the details of new RAC awards once they have been made later this year. Please describe whether CMS plans to make sure that "good actors" are going to be separated from other providers and rewarded with less RAC monitoring. Will "good actors" receive a lower volume of medical record requests? Less frequent audits? A smaller number of pulled files?**

Answer: CMS is currently in the procurement process for the next round of Recovery Audit Program contracts and plans to award these contracts this year. In February 2014, CMS announced a number of changes to the Recovery Audit Program that will take effect with the new contract awards as a result of stakeholder feedback.[5] CMS believes that improvements to the RAC program will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency. One of the improvements is that ADR limits will be adjusted in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits.

9. **Please provide the total number of claims appealed by provider type (Part A hospitals claims, other Part A claims, Part B claims, DMEPOS claims) at each level of the appeals process. What is the success rate (fully-favorable, partially favorable or unfavorable) by each provider type previously listed at each level of the appeals process for Fiscal Years 2010- present.**

Answer: The first two tables below provide appeals data for level one of the appeals process. The first table identifies the number of claims appealed by fiscal year, and the second table identifies the decisions on those appealed claims for each fiscal year.

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[4] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Provider-Resource.html

[5] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf

Level 1 (Medicare Administrative Contractor, or MAC, Redeterminations) Processed Appeals[6]

	FY2010	FY2011	FY2012	FY2013	FY2014[7]
Part A - Inpatient Hospital	7,844	45,090	212,931	436,200	217,682
Part A - All Other	254,706	313,338	370,017	349,390	200,839
Part B	1,847,277	1,862,499	2,096,675	1,928,757	999,079
DME	503,532	644,866	831,782	1,304,613	751,325
Total	**2,613,359**	**2,865,793**	**3,511,405**	**4,018,960**	**2,168,925**

Level 1 (MAC Redeterminations) Success Rates[8]

	FY2010	FY2011	FY2012	FY2013	FY2014[9]
Part A - Inpatient Hospital					
Fully Favorable	23.2%	20.4%	10.5%	8.8%	10.9%
Partially Favorable	2.3%	2.3%	0.3%	0.1%	0.2%
Unfavorable	74.4%	77.3%	89.2%	91.2%	88.9%
Part A - All Other					
Fully Favorable	41.3%	39.4%	29.7%	26.9%	28.1%
Partially Favorable	3.5%	5.0%	3.8%	4.5%	5.7%
Unfavorable	55.2%	55.6%	66.5%	68.6%	66.2%
Part B					
Fully Favorable	52.6%	54.0%	50.5%	44.6%	45.9%
Partially Favorable	3.1%	3.1%	2.1%	2.3%	2.9%
Unfavorable	44.3%	42.9%	47.4%	53.1%	51.2%
DME					
Fully Favorable	44.0%	41.3%	34.3%	28.7%	25.5%
Partially Favorable	5.3%	6.2%	5.2%	5.4%	4.3%
Unfavorable	50.7%	52.4%	60.5%	65.8%	70.2%

The remaining two tables below provide appeals data for level two of the appeals process. The first table identifies the number of claims appealed by fiscal year, and the second table identifies the decisions on those appealed claims for each fiscal year.

Level 2 (Qualified Independent Contractors, or QICs, Reconsiderations) Processed Appeals[10]

	FY2010	FY2011	FY2012	FY2013	FY2014[11]
Part A - Inpatient Hospital	3,833	15,404	87,991	357,769	284,196
Part A - All Other	67,705	76,869	88,131	150,076	99,779

[6] Based on appeals processed (in claims) in the fiscal year. Dismissed claims are included in the number of processed claims.
[7] FY 2014 includes 6 months data of Oct 2013 to Mar 2014.
[8] Based on appeals processed (in claims) in the fiscal year. Dismissed claims are excluded from rate calculations.
[9] FY2014 includes 6 months data of Oct 2013 to Mar 2014.
[10] Based on appeals (in claims) processed in the fiscal year. Dismissed, escalated and misrouted claims are included in the number of processed claims.
[11] FY2014 includes 8 months data of Oct 2013 to May 2014.

Part B	313,243	276,219	378,950	372,910	252,221
DME	108,478	125,996	230,644	381,647	356,594
Total	**493,259**	**494,488**	**785,716**	**1,262,402**	**992,790**

Level 2 (QIC Reconsiderations) Success Rates[12]

	FY2010	FY2011	FY2012	FY2013	FY2014[13]
Part A - Inpatient Hospital					
Fully Favorable	11.4%	10.8%	17.2%	16.9%	21.0%
Partially Favorable	0.5%	3.1%	0.0%	0.0%	0.1%
Unfavorable	88.1%	86.1%	82.8%	83.1%	78.9%
Part A - All Other					
Fully Favorable	8.2%	9.4%	6.9%	6.5%	10.9%
Partially Favorable	3.0%	2.6%	1.8%	1.2%	1.9%
Unfavorable	88.8%	88.1%	91.3%	92.3%	87.2%
Part B					
Fully Favorable	23.8%	26.0%	24.2%	24.0%	18.6%
Partially Favorable	4.5%	4.1%	3.3%	3.1%	3.2%
Unfavorable	71.7%	70.0%	72.5%	72.9%	78.2%
DME					
Fully Favorable	7.6%	10.3%	11.8%	10.3%	6.4%
Partially Favorable	1.5%	1.3%	1.3%	0.9%	0.8%
Unfavorable	90.9%	88.4%	86.8%	88.8%	92.9%

10. How many appeals are from rural providers? Please provide information CMS has on success rates throughout the Medicare appeals process for these providers.

11. How many appeals are made by small providers? Please provide all information CMS has on success rates by size of practice throughout the Medicare appeals process.

Answer to #s 10 and 11: Data specific to rural or small providers are not available within CMS' reporting systems.

12. Is Medicare appeals data publicly available? If not, will CMS commit to make public all of its Medicare appeals data?

Answer: CMS publishes an Annual Fact Sheet containing level one and level two appeals calendar-year data on its publicly-available website. The Annual Fact Sheet includes the following information, separated by Part A, Part B, and DME:

- Denied claims,
- Claims appealed,

[12] Based on appeals processed (in claims) in the fiscal year. Dismissed, escalated and misrouted claims are excluded from rate calculations.
[13] FY2014 includes 8 months data of Oct 2013 to May 2014.

- Top ten appeals categories,
- Appeal Decisions, categorized as favorable, partially favorable, and unfavorable/dimissals, and
- Timeliness of appeal decisions.

CMS also reports Recovery Auditor-specific and Zone Program Integrity Contractor(ZPIC)-specific decisions for level two appeals within this Annual Fact Sheet. This Annual Fact Sheet has been published on CMS's publicly-available website since 2008.[14]

Additionally, when Congress expanded the Recovery Audit program nationwide, it included a requirement that CMS submit an Annual Report to Congress including information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program. CMS includes detailed information on the number Recovery Auditor determinations that are appealed by providers in its Annual Report to Congress.

13. In November 2012, the HHS Inspector General (OIG) issued a report that identified several challenges with the Medicare appeals process.[15] According to the OIG, CMS concurred fully or in-part with all of OIG's recommendations to the agency. Please describe the progress CMS has made in addressing these recommendations as well as what remains outstanding.

Answer: In the November 2012 Report, the OIG provided 10 recommendations to improve the Medicare appeals process. Of these, five recommendations applied to both CMS and the Office of Medicare Hearings and Appeals (OMHA) within the Department of Health and Human Services, one applied to CMS only, and the remaining four applied to OMHA only. The six recommendations applying to CMS and the status on each recommendation are identified in the table below.

OIG RECOMMENDATION	CMS STATUS
RECOMMENDATION 1: OMHA and CMS should develop and provide coordinated training on Medicare policies to Administrative Law Judges (ALJs) and QICs	In 2013, CMS provided four policy-specific training sessions: • Coverage of Orthotics and Prosthetics • Prior authorization of durable medical equipment and supplies • JIMMO - In 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius. CMS provided clarifications to existing program guidance and new educational materials. In early 2014, CMS provided policy training on CMS Final Rule 1599-F, referred to as the two-midnight rule. The two midnight rule modified and clarified CMS's longstanding policy on how

[14] The Annual Fact Sheets can be downloaded at: http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html.

[15] Ofc of Inspctr Gnrl, Dep't of Hlth & Hmn Srvcs, *Improvements Are Needed at the Administrative Judge Level of Medicare Appeals*, OEI-02-10-00340, (Nov. 2012), *available at* https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf.

	Medicare contractors review inpatient hospital and critical access hospital (CAH) admissions for payment purposes. We are coordinating with OMHA to finalize topics that will be discussed at OMHA's Judicial Educational Symposium to be held this summer.
RECOMMENDATION 2: OMHA and CMS should identify and clarify Medicare policies that are unclear and interpreted differently	We agree with the OIG that there is value in tracking appeals so we can evaluate the cases that are being reversed and determine which Medicare policies are most often at issue in these cases. Similarly, we agree that in some instances, as a result of reversals at higher adjudicative levels, it might be beneficial to clarify a particular Medicare policy. Currently, the Administrative Qualified Independent Contractor (AdQIC) identifies and reports to CMS, on an annual basis, policies and procedures that seem to be unclear, based on appeals outcomes, and provides recommendations for revisions. CMS considers the information contained in these reports as it has and continues to collaborate with the OMHA to identify training and educational opportunities for appeal adjudicators to ensure there is a proper understanding of Medicare policies and regulations. In addition, CMS believes that appeals outcomes at the ALJ level should be used by lower level adjudicators to evaluate their review strategies. Thus, CMS continues to look at ways to help ensure that all contractors (MACs, RAs, ZPICs, and QICs) are evaluating the outcomes of their appeals at the ALJ level and appropriately considering the applicable ALJ reversal rates in developing any future review strategies. This approach will help ensure that resources at all levels of the appeals process are being used most effectively. Finally, in FY 2014, CMS created the ZPIC Appeals Contractor that will review and analyze ZPIC appeals vulnerabilities, collect information to develop a best practices document, and provide data analysis and recommendations for improvements to the ZPIC review process.
RECOMMENDATION 3: Standardize case files and make them electronic	CMS has made significant progress in standardizing and implementing electronic case files at levels one and two of the appeals process. In February of 2014, four Medicare Administrative Contractors (MACs) began processing a portion of Part A redeterminations in the Medicare Appeals System (MAS). The MAS provides centralized appeals data storage, enhances trending capabilities for agency initiatives, reduces operational costs, and automates data entry from CMS source systems. Today, 35-40% of the national Part A redeterminations are electronic and processed through MAS. In Spring 2013, OMHA and CMS worked together to identify where interfaces between our appeals processing systems will be needed to ensure efficiencies in the appeals process and create standard procedures, where possible. CMS also attended the OMHA Medicare Appeals Data Summit in June 2014 to discuss the Departmental goal of a seamless and efficient administrative appeals process.

RECOMMENDATION 4: Revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence.	CMS has provided extensive guidance to lower level appeals contractors (MACs and QICs) to ensure that a complete and accurate record is forwarded to the ALJ level in order to reduce the need for ALJ's to request additional evidence. In addition, CMS continues to work collaboratively with OMHA to identify reasons for the late submission of evidence that may require additional guidance to the ALJs or lower level appeals contractors.
RECOMMENDATION 5: Improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.	As discussed above with our update to OIG's recommendation 2, CMS established a ZPIC Appeals Contractor to review and analyze ZPIC appeals vulnerabilities and improve ZPIC approaches to fraud investigation. We are not seeking statutory authority to postpone appeals for appellants who are under fraud investigation. As stated in our response to the OIG's recommendation, suspending appeals could potentially impact due process rights guaranteed to appellants. In addition, given our current policy to not suspend appeals in such cases, we believe that implementing a delay might tip-off providers about the fraud investigation.
RECOMMENDATION 10: CMS should continue to increase participation in ALJ appeals.	In 2011 hired additional Contractor Medical Directors to support CMS anti-fraud and error rate reduction efforts by defending decisions at the ALJ level. This program was moved to the MACs in FY 2012. As a result, there are now CMDs dedicated to serving as expert witnesses at appeal hearings. This project supports agency administrative actions by ensuring there are adequate CMDs that can serve as expert witnesses for the agency at the ALJ level. In a pilot program, CMS had previously had success with reducing the overturn rate on appeals by having a physician participate at the ALJ level. In FY 2014, CMS will expand the presence of the ZPICs at ALJ hearings so that they can present CMS's reasoning for the determination being appealed. CMS will also continue to collaborate with OMHA to identify training and educational opportunities for appeal adjudicators to ensure there is a proper understanding of Medicare policies and regulations. In FY 2012, Recovery Auditors continued to increase their participation in ALJ appeal hearings. Appeals involvement by Recovery Auditors aids in contractor and provider education, as it presents an additional forum for discussion and can identify incorrect billing practices to the provider and CMS policies in need of further clarification. This also presents an opportunity for the Recovery Auditors to clarify any policy questions the ALJ(s) may have during the hearing process. As discussed in the 2012 OIG report, CMS continues to have QICs participate in 10 percent of ALJ hearings. While CMS would like to increase QIC participation in ALJ hearings, funding limitations have affected our ability to increase beyond current participation rates.

14. Please provide a list that you can share with the Committee detailing how CMS is prioritizing recommendations from the Government Accountability Office and others

to implement enhanced screening procedures authorized by the Patient Protection and Affordable Care Act to further strengthen provider enrollment.

Answer: CMS has implemented many of the important Affordable Care Act authorities that have strengthened provider enrollment. The provisions implemented to date have addressed vulnerabilities identified by the Government Accountability Office (GAO) and the HHS and Office of Inspector General. Specifically, CMS has implemented the following Affordable Care Act provisions under Title VI, Subtitle E, Medicare, Medicaid and CHIP Program Integrity Provisions.

Provision	Implementation
Section 6401 – Provider Screening and other enrollment requirements under Medicare, Medicaid and CHIP	CMS issued a final rule effective on March 25, 2011, that established: • risk-based screening requirements based on categories' of providers risk to Medicare, Medicaid and CHP • application fees for the screening of Medicare and Medicaid applicants • a revalidation process of all existing providers under the enhanced requirements. As a result of this final rule, CMS has screened 770,000 providers and suppliers and has deactivated the billing privileges of 260,000 provider practice locations, and revoked the billing privileges of an additional 17,534 providers.
Section 6401 – Temporary moratorium on enrollment of new providers	CMS issued a final rule effective March 25, 2011 that established the Secretary's authority to impose moratoria in Medicare, Medicaid and CHIP. In 2013 and 2014, CMS imposed moratoria in seven geographic areas for home health and ambulances. These moratoria are still in place and are being actively monitored.
Section 6402 – Inclusion of the National Provider Identifier on all applications and claims	CMS issued an Interim Final Rule on May 5, 2010, and issued a Final Rule on April 24, 2012, that required all Medicare and Medicaid providers to submit enrollment applications and claims with their NPI.
Section 6405 – physicians who order items or services required to be Medicare enrolled physicians or eligible professionals	CMS issued an Interim Final Rule on May 5, 2010, and issued a Final Rule on April 24, 2012, that required providers that order and refer durable medical equipment, home health services, IDTF services or clinical labs to be enrolled in Medicare. On May 22, 2014, CMS issued a Final Rule that extended the enrollment requirement to providers that prescribe drugs under Part D.

The GAO identified the following provider enrollment provisions that CMS has not yet implemented.

Provision	Implementation
Section 6401 Requires disclosure in enrollment applications of affiliations with provider or supplier with uncollected debt or who is suspended, excluded or terminated from Federal programs	On April 24, 2013, CMS issued a proposed rule that would permit CMS to deny Medicare enrollment if the provider, supplier or current owner thereof was the owner of another provider or supplier that had a Medicare debt when the latter's enrollment was voluntarily or involuntarily terminated or revoked. CMS is considering potential provider burden in the development of additional disclosure requirements under this section.
Section 6402 Surety Bond Requirements	CMS has not scheduled for publication new regulations under this authority. CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about $1.6 million directly from surety companies, and has collected an additional $18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame.

15. What policies does CMS have in place to prevent contractors and providers who have serious delinquent tax debt to be engaged with Medicare? How effective are these measures? Please provide data to support your responses.

Answer: CMS and our enrollment contractors use available Federal databases and other tools to screen newly enrolling providers and suppliers and ensure they are eligible to participate in Medicare, including verification of identify through the Social Security Administration, license and certification through the state licensing boards, as well as searches against the General Systems Administration (GSA) debarments and the HHS Office of Inspector General (OIG) exclusion list for all individuals listed on the application. Once approved, enrolled providers and suppliers are systematically compared monthly to the SSA Death Master File and the Medicare Exclusion Database. Any providers or suppliers that match against these lists are immediately deactivated, if deceased, or revoked, if excluded. At this time, CMS does not have authority to take administrative action such as denial or revocation as a result of delinquent tax debt.

In addition to implementing risk-based screening and performing the revalidation of all currently enrolled providers, in April 2013, CMS issued a proposed rule (78 FR 25013) that would strengthen the requirements for provider enrollment. The rule includes proposals that would permit CMS to deny or revoke enrollment for a broader range of felony convictions, to deny enrollment if the individual applying is affiliated with a provider or supplier that has an outstanding Medicare debt, and to revoke a provider if there is a pattern or practice of submitting claims that fail to meet Medicare requirements.

Additionally, as part of standard contracting processes potential contractors are also screened to ensure they meet all requirements. Current statute limits the ability of the contractors who conduct CMS's provider screening from accessing Internal Revenue Service data.

Relating to CMS contractors, the Federal Acquisition Regulation (FAR) at 48 CFR 9.104 provides the general standards the Government uses to determine if a prospective contractor is considered responsible. No purchase or award can be made unless the contracting officer makes an affirmative determination of responsibility. In making a determination of responsibility before awarding a contract, agency Contracting Officers consider, among other things, the information contained in the Federal Awardee Performance and Integrity Information System. See FAR 9.104-6. Agencies also review and consider the information contained in the System for Award Management (SAM). Specific to your question regarding contractor's tax debts, within the SAM system, prospective contractors complete FAR 52.209-5 – Certification Regarding Responsibility Matters, in which they self-certify if they have or have not "within a three-year period preceding this offer, been notified of any delinquent Federal taxes in an amount that exceeds $3,000 for which the liability remains unsatisfied." This is included in the information used in making the determination of responsibility prior to contract award.

Representative Mark Meadows

1. **What factors have contributed to the increased number of audits being referred to Administrative Law Judges, or ALJs, at the Office of Medicare Hearing and Appeals, or OMHA? What policy changes by CMS in 2012 contributed to this backlog? What additional factors under CMS' control could have created this situation?**

Answer: Beginning in 2009, CMS implemented changes to enhance its monitoring of payment accuracy in the Medicare FFS program. Based on recommendations from the OIG, CMS tightened its methodologies related to how it calculates the Medicare payment error rate, with a view toward improving provider claims documentation and compliance with Medicare's billing, coverage, and medical necessity requirements. MACs also implemented stricter policies for claims acceptance criteria, and initiated a series of focused medical review initiatives. Other CMS efforts to eliminate payment error and fraud based on Executive Order 13520, the Affordable Care Act, and IPERA resulted in additional denied claims and the identification of overpayments. With the increase in these types of claim denials, we have seen an overall increase in appeal requests.

2. **What policy changes can CMS implement to facilitate the reduction of the appeals backlog?**

Answer: The Department has formed an intra-agency workgroup tasked with developing recommendations to improve the Medicare appeals process and address the backlog of appealed claims. We are working diligently to identify short and long-term solutions that can be implemented expeditiously.

3. **What can CMS specifically do to reduce the appeal overturn rate at the ALJ level below 20%?**

Answer: CMS continues to work with Recovery Auditors, QICs, ZPICs, and MACs Contractors to ensure that determinations are as accurate as possible. It is important to remember that claims that are more likely to succeed tend to be appealed, and thus the ALJ reversal rate does not correlate to a rate of error in contractor decision-making generally. Indeed, appeals are overturned for a variety of reasons including:

- ALJs are bound by Medicare statute, National Coverage Determinations (NCDs), and CMS rulings. ALJs are required to provide substantial deference to, but are not bound by, CMS manuals or Local Coverage Determinations (LCDs). Initial claim determinations, Recovery Auditor determinations, and first level claim appeal decisions are based on all CMS policies including manuals and LCDs. This creates inconsistencies among the decision criteria applied.

- Providers sometimes produce additional documentation at an ALJ hearing that was not provided previously. Though CMS has provided outreach and education to providers emphasizing the importance of providing all supporting documentation, new information provided to the ALJ can result in a different decision.

CMS contractors continue to increase their participation in ALJ appeal hearings. In 2011, CMS hired additional Contractor Medical Directors to support CMS anti-fraud and error rate reduction efforts by defending decisions at the ALJ level. This program was moved to the MACs in FY 2012. As a result, there are now CMDs dedicated to serving as expert witnesses at appeal hearings. This project supports agency administrative actions by ensuring there are adequate CMDs that can serve as expert witnesses for the agency at the ALJ level. In a pilot program, CMS had previously had success with reducing the overturn rate on appeals by having a physician participate at the ALJ level. In FY 2014, CMS will expand the presence of the ZPICs at ALJ hearings so that they can present CMS's reasoning for the determination being appealed. CMS will also continue to collaborate with OMHA to identify training and educational opportunities for appeal adjudicators to ensure there is a proper understanding of Medicare policies and regulations.

Further, CMS continues to work with OMHA to identify ways to reduce the backload at the ALJ level. Through this working relationship, CMS has already improved the quality and completeness of documents provided to the ALJs when a case moves from the second level of the appeals process to OMHA.

4. Can CMS make policy changes that allows for CMS to not collect recoupment payments while the ALJ appeals process is ongoing? If so, what are they?

Answer: CMS does not have statutory authority to modify its debt collection regulations in the manner you suggest. Section 1893(f)(2)(A) of the Social Security Act (Act) limits CMS's recoupment of Medicare overpayments only during the first two levels of appeal and does not authorize suspension of debt collection during subsequent appeals. In the absence of express statutory authority to further delay recoupment, CMS has no statutory authority to delay recoupment after the second level of appeal. However, CMS is authorized to grant a provider or supplier an extended repayment schedule of up to 60 months if repayment of an overpayment constitutes a hardship (Social Security Act § 1893(f)(1); 42 CFR 401.607). Additionally, if the provider or supplier ultimately is successful in its ALJ appeal, CMS is required to return all monies collected on the debt with interest.

5. What steps can Congress take to facilitate the reduction of the Medicare appeals backlog?

Answer: The Department has formed an intra-agency workgroup tasked with developing recommendations to improve the Medicare appeals process and address the backlog of appealed claims. We are working diligently to identify short and long-term solutions that can be implemented expeditiously.

6. Why has CMS not reprogrammed money from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, as permitted under Public Law 108-173 Subtitle D, Sec. 931 (c), to OMHA to address the backlogs?

Answer: Section 931c of the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) does not provide CMS the authority to reprogram money from the Federal Hospital Insurance or Federal Supplemental Medical Trust Fund for the purpose of ensuring timely appeals. Section 931c is a provision that was not funded by the Congress—it is merely an authorization for an appropriation. While the Congress "authorized to be appropriated" funding for this purpose, it did not subsequently appropriate funding to implement this provision.

Representative Tammy Duckworth

1. **In its response to OIG's recommendations in the Oct. 2012 report entitled "CMS Has Not Promulgated Regulations to Establish Payment Requirements for Prosthetics and Custom-Fabricated Orthotics," CMS concurred with OIG's recommendations, stating, "The CMS concurs with this recommendation and proposed regulations are under development to implement the BIPA provisions." Can you provide an update on the status of these proposed regulations? Given that the statute was enacted 14 years ago, can you explain what has caused such a lengthy delay?**

Answer: The Medicare, Medicaid, and SCHIP Benefits Improvement and Portability Act of 2000 (BIPA) required that no payment be made for an item of custom-fabricated orthotics or for an item of prosthetics unless furnished by a qualified practitioner and fabricated by a qualified practitioner or a qualified supplier at a facility that meets criteria the Secretary determines appropriate. CMS is currently developing a notice of proposed rulemaking, and anticipates it will be published this calendar year.

The statute also directed the Secretary to engage in negotiated rulemaking with interested parties to define the parameters of the requirements. CMS established a Committee on Special Payment Provisions for Prosthetics and Certain Custom Fabricated Orthotics in October 2002. The Committee met nine times from October 2002 to July 2003. Although the Committee failed to reach consensus, the Committee did concur on certain recommendations. Since that time, we have been seeking ways to pursue many of these recommendations and to achieve a consensus on these important issues.

While CMS has not yet implemented certain provisions of BIPA through rulemaking, CMS has taken significant steps to limit who can be paid for prosthetics and custom fabricated orthotics. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required all DMEPOS suppliers, including those furnishing orthotics and prosthetics, to become accredited and required the Secretary to designate independent accreditation organizations (AO) in order to evaluate suppliers for compliance with quality standards that are required to be met in order to be accredited. The Medicare Improvements for Patients and Providers Act Of 2008 (MIPPA) set a deadline of September 30, 2009, for all suppliers to become accredited.

CMS published the Final Rule implementing the MMA requirements for accreditation organizations on August 18, 2006 (71 FR 48354). These rules specified the criteria that all approved accreditation organizations must meet. In December 2006, we approved 11 accreditation organizations, which are now 10 accreditation organizations because of the merger of two of the accreditation organizations. These accreditation requirements are an important part of our efforts to assure that only qualified providers and suppliers are able to provide and bill for services and supplies.

2. **Medicare has provided limited relief to hospitals by allowing them to rebill denied Part A admissions as Part B services. This is a step in the right direction. But Medicare has not made this relief, or any relief at all available to other health care sectors. For example, there is no similar relief for Part B practitioners like in orthotics and**

prosthetics. Has CMS considered providing similar relief to other providers as it has for hospitalization services?

Answer: Part A/B rebilling is unique to hospitals in that if an inpatient admission is denied, the hospital previously was not paid (or only paid for a very limited amount of services). Following a reasonable and necessary denial of a Part A inpatient claim, a hospital can submit a Part B inpatient claim for the items and services that would have been payable had the beneficiary been treated as an outpatient rather than admitted as an inpatient, provided the Part B inpatient claim is timely filed. Under the Medicare statute, Part B practitioners and suppliers bill Part B of the Medicare program. If their claim is denied, they have the opportunity to appeal the denial of their claim.

Hearing Follow-up Question/Answer
May 20, 2014
House Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements
OIG Witness: Brian Ritchie

Based on OIG's October 2012 report titled: *CMS Has Not Promulgated regulations To Establish Payment Requirements for Prosthetics and Custom-Fabricated Orthotics,* (OEI-07-10-00410), OIG received a communication September 24, 2013, from CMS, regarding their Final Management Decision, as to their plan to address OIG's recommendation, which stated "CMS should promulgate regulations to implement the BIPA payment requirements." At that time, CMS indicated they had drafted an NPRM that was undergoing internal CMS review. To date, OIG has not received CMS's Annual Status Update on the status of their NPRM which would address this unimplemented recommendation once finalized. OIG followed up with CMS on June 9, 2014, and learned that the status of this outstanding OIG recommendation remains unimplemented.

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